MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6464

CERTIFICATE OF DEATH

06423

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 6218 - 27th Street, North
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia — Middle: Madlyn — Last: Abernathy

4. DATE OF DEATH: Month: June — Day: 17, — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: November 15, 1912

9. AGE (In years lost birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George Smith

14. MOTHER'S MAIDEN NAME: Lynette Heuser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unascertainable

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Melanoma in Brain, Lungs
DUE TO (b): Liver Heart Kidneys
DUE TO (c): Malignant Melanoma

190X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis due to E coli

600.0

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 28, 19 57, to June 17, 19 57, that I last saw the deceased alive on June 17, 19 57, and that death occurred at 7 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur J. Garceau M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/18/57
PHYSICIAN'S NAME (Type): Arthur J. Garceau, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: June 21 1957
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.
22d. LOCATION (City, town, or county) (State): ARLINGTON VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Arlington Funeral Home
ADDRESS: 3901 N. Fairfax Dr. Arlington Va.
24a. REC'D BY REGISTRAR DATE: JUN 21 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6465 **CERTIFICATE OF DEATH** 06424

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 67 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: North Carolina b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jacksonville 70X-3
d. STREET ADDRESS: 2211 Onslow Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice Middle: Clarissa Last: Albert

4. DATE OF DEATH: Month: June Day: 27 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 16 December 1919
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months: 6 Days: 11
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William D. Morse
14. MOTHER'S MAIDEN NAME: Clarissa Tyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
(b) Mitral Insufficiency — 6 months
DUE TO
(c) Rheumatic fever — years

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 21 April, 1957 to 27 June, 1957, that I last saw the deceased alive on 27 June, 1957, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard J. Sanders M.D.
ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland
DATE SIGNED: 6/28/57
PHYSICIAN'S NAME (Type): Richard J. Sanders, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 6/28/57
22c. NAME OF CEMETERY OR CREMATORY: Walnut Hill
22d. LOCATION (City, town, or county) (State): Baraboo, Wisconsin

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 6-30-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6466

CERTIFICATE OF DEATH

06425

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Monrovia
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

73

3. NAME OF DECEASED (Type or print): First: Annie= Middle: Lost: Allnutt

4. DATE OF DEATH: Month: June Day: 10 Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2/2/93

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George E. Brown

14. MOTHER'S MAIDEN NAME: Jennie Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Record Address:

1

I

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Complete Heart Block — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
443x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular disease — 10 yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 433.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/26, 1957, to 6/9, 1957, that I last saw the deceased alive on 6/9, 1957, and that death occurred at 12:30AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. — ADDRESS (Street, city or town, state): Sandy Spring — DATE SIGNED: Ned 6/10/57

PHYSICIAN'S NAME (Type): A. D. Bonifant, M. D. — Sandy Spring, Maryland

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 12

22c. NAME OF CEMETERY OR CREMATORY: Montgomery Methodist

22d. LOCATION (City, town, or county) (State): Clagettsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md.

24a. REC'D BY REGISTRAR DATE 6/13/57

24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

6467

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06426 218

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 15yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Asbury Methodist Home

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg x 2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

3. NAME OF DECEASED (Type or print): First: Maggie — Middle: Brown — Last: Althoff

4. DATE OF DEATH: Month: June — Day: 21 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 13-1869

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months: 9 — Days: 8 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home Work

11. BIRTHPLACE (State or foreign country): Culpepper. Va,

12. CITIZEN OF WHAT COUNTRY?

1

13. FATHER'S NAME: John Thomas Brown

14. MOTHER'S MAIDEN NAME: Susan Jane Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Asbury Methodist Home Records. — Address: Gaithersburg Md

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/21/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-24-57

22c. NAME OF CEMETERY OR CREMATORY: Fair View

22d. LOCATION (City, town, or county) (State): Culpepper. Va,

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner — ADDRESS: Gaithersburg. Md.

24a. REC'D BY REGISTRAR DATE June 22-57

24b. REGISTRAR'S SIGNATURE: Alinda G. Cooke

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06427

6468 **CERTIFICATE OF DEATH**

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Colorado
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denver 44X-3
d. STREET ADDRESS: 3030 East 17th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herman; Middle:; Last: Appel
4. DATE OF DEATH: Month: June; Day: 9; Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 1879
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cigar Maker (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Louis Appel
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leonard Appel 4004 Virgilia, Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
420.0
DUE TO
(b) Congestive Heart Failure — 4 weeks
DUE TO
(c) Pulmonary Emboli, Recurrent — 3 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 1, 1957, to JUNE 9, 1957, that I last saw the deceased alive on JUNE 9, 1957, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip R. James M.D. ADDRESS (Street, city or town, state): 6921-C LaReDon Rd. Bethesda, Md. DATE SIGNED: 6-4-57

PHYSICIAN'S NAME (Type): Philip R. James

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/13/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Nebo Cemetery
22d. LOCATION (City, town, or county) (State): Denver, Colorado

23. FUNERAL DIRECTOR'S SIGNATURE: B. Wanzenosky & Sons
ADDRESS: 3501 14th St., N. W.
24a. REC'D BY REGISTRAR DATE: 6-13-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6435

CERTIFICATE OF DEATH

06428

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sam. & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 602 Easley St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Nettie Middle Marie Lastname Bakersmith
4. DATE OF DEATH: Month June Day 17 Year 1957
5. SEX: Fe
6. COLOR OR RACE: Cau
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 18, 1900
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Amer. Forestry Ass
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Barns
14. MOTHER'S MAIDEN NAME: Margaret Turner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-01-1253
17. INFORMANT: Hosp Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Secondary anemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
581.1
DUE TO (b): hemorrhage from Esophageal Varices — 3 weeks
DUE TO (c): Cirrhosis of Liver (Laennec's) — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyelonephritis & Cystitis; Glomerulonephritis; Nephrolithiasis
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1952 to June 17, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: N C Shoemaker M.D. — ADDRESS (Street, city or town, state): 8005 Woodbury Drive — DATE SIGNED:
PHYSICIAN'S NAME (Type): N.C. SHOEMAKER, M.D. — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/20/57
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 6/19/57
24b. REGISTRAR'S SIGNATURE: J Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06429

6469

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X 2 Bethesda
d. STREET ADDRESS: 4833 Broad Brook Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Victor — Middle Stanislaus — Last Baril
4. DATE OF DEATH: Month June — Day 23 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 27, 1899
9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Economist
10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Labor
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Archie Baril
14. MOTHER'S MAIDEN NAME: Victoria Brisson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Margaret Baril — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple myeloma — INTERVAL BETWEEN ONSET AND DEATH: 6 months
203X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 521X
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Lung Abscess, Right Lower Lobe
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 5, 1957, to June 23, 1957, that I last saw the deceased alive on June 23, 1957, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr Joseph Kenrick M.D. — ADDRESS (Street, city or town, state): 6450 Wisconsin Ave, Bethesda, Md — DATE SIGNED: 6/23/57

PHYSICIAN'S NAME (Type): DR. JOSEPH KENRICK

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/27/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem
22d. LOCATION (City, town, or county) (State): Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6470 **CERTIFICATE OF DEATH** Reg. Dist. No. 277 06430

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Purdum
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Purdum
d. STREET ADDRESS: Monrovia Rfd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Middle Frances Last Beall
4. DATE OF DEATH: Month June Day 18 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec, 28 1865
9. AGE (In years lost birthday): 91 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Benjamin Franklin Burdette
14. MOTHER'S MAIDEN NAME: Charity Ane Watkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): #### (If yes, give war or dates of service): #####
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Emma E, Beall Address: Monrovia R,F,D,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

332 x

DUE TO (b) Generalized Arteriosclerosis — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No injury
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1935, to June 18, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: M. McKendree Boyer M.D. ADDRESS (Street, city or town, state): Druid Theatre Building DATE SIGNED: June 19, 1957

PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D. Dr. McKendree M. Boyer Damascus Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 21 57
22c. NAME OF CEMETERY OR CREMATORY: Mountain View
22d. LOCATION (City, town, or county) (State): Purdum Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Garber ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR DATE: June 25/57
24b. REGISTRAR'S SIGNATURE: Della W. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6471

CERTIFICATE OF DEATH

06431

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marlen Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 16152
d. STREET ADDRESS: 2028 - Powhatan Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

90

3. NAME OF DECEASED (Type or print): First: Anna; Middle: Katharina; Last: Beck
4. DATE OF DEATH: Month: June; Day: 19; Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 28, 1871
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Konrad Weiss
14. MOTHER'S MAIDEN NAME: Marie Louise Tattschling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. James Noble — Address: Niece

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 16 days
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — Yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
450.0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 10, 1956, to June 19, 1957, that I last saw the deceased alive on June 15, 1957, and that death accurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert O. Rogers M.D. — ADDRESS (Street, city or town, state): 1919 Seminary Rd. Silver Spring, Md. — DATE SIGNED: 6-19-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 21, 1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va
23. FUNERAL DIRECTOR'S SIGNATURE: J. Ray Lee & Sons — ADDRESS: Washington DC
24a. REC'D BY REGISTRAR: DATE 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06432

6436

CERTIFICATE OF DEATH

Reg. Dist. No. 773

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San + Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1615.2
d. STREET ADDRESS: 5720 29th Ave Apt 102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Lee Last: Bell
4. DATE OF DEATH: Month: 6 Day: 6 Year: 1957

5. SEX: Fe
6. COLOR OR RACE: Colc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-7-79
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hsfi
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Jesse Ruffner
14. MOTHER'S MAIDEN NAME: Emma Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days
DUE TO
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of pancreas — months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 25, 1957, to June 6, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 7:34 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 7105 Riggs Rd. Hyattsville, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6/8/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince George County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR: DATE JUN 7 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1FilmG217 6-20-57 et

06433

6472

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 2402 Lindell Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RUSSELL — Middle M. — Last BEVLIN
4. DATE OF DEATH: Month 6 — Day 9 — Year 19 57

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR. 12, 1900
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi Cab Driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1923-1928
16. SOCIAL SECURITY NO.: 579-22-1228
17. INFORMANT: Charles F. Venable — Address: Silver Spring, Md. 11104 Bucknell Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary insufficiency — 1 year
DUE TO
(c) Coronary sclerosis — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1956 to June 9, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel B. Washington M.D. — ADDRESS (Street, city or town, state): 6234 Georgia Ave NW Washington — DATE SIGNED: 6/7/57

PHYSICIAN'S NAME (Type): Daniel B. Washington M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-12-57
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL
22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA.

23. FUNERAL DIRECTOR'S SIGNATURE: F. Collins — ADDRESS: Wash. D.C.
Francis J. Collins - 3821 14th.St.N.W.
24a. REC'D BY REGISTRAR — DATE: JUN 12 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06434

6473 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

COUNTY: Montgomery — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring — LENGTH OF STAY (in this place): 40 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 10,203 Brookmoor Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring

STREET ADDRESS (If rural give location): 10,203 Brookmoor Drive

3. NAME OF DECEASED: (Type or Print) (First) Julian (Middle) William (Last) Bieber

4. DATE OF DEATH: (Month) June (Day) 9 (Year) 19 57

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: July 10, 1899

9. AGE Last birthday: 57 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry J. Bieber

14. MOTHER'S MAIDEN NAME: Lissetta R. Huth

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 214-03-9439

17. INFORMANT & ADDRESS: Mrs. Carlotta B. Jackson, 10,203 Brookmoor Dr.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332 X

Immediate cause (a) Cerebral thrombosis — Interval Between Onset And Death: 3 wks

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 17, 1957, to June 9, 1957, that I last saw the deceased alive on June 3, 1957 and that death occurred at 3:00 am, from the causes and on the date stated above.

SIGNATURE: A. F. Thibadeau (Degree or title) M.D. — ADDRESS: 10111 Colesville Rd Silver Spring — DATE SIGNED: 6/9/57

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: June 11, 1957 — NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery — LOCATION (City, town, or county) (State): Washington, D. C.

DATE REC'D BY LOCAL REGISTRAR: 6-17-57 — REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR: Warner E. Pumphrey — ADDRESS: Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6474 **CERTIFICATE OF DEATH** 06435

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 635 Otis Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Benjamin Middle: (No middle name) Last: Blake
4. DATE OF DEATH: Month: June Day: 30 Year: 19 57
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 6, 1912
9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Gilbert Blake
14. MOTHER'S MAIDEN NAME: Annie (Last name unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
592x
DUE TO (b) Chronic Glomerulonephritis — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
443x Hypertensive Cardiovascular Disease
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 20, 1957, to June 30, 1957, that I last saw the deceased alive on June 30, 1957, and that death occurred at 7.20A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: P. Roy Vagelos M.D. ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED: 6/30/57
PHYSICIAN'S NAME (Type): P.Roy Vagelos, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-5-1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat Cemetery
22d. LOCATION (City, town, or county) (State): Virginia VA.
23. FUNERAL DIRECTOR'S SIGNATURE: Cornish & Cornish ADDRESS: 2121-10-St N.W.
24a. REC'D BY REGISTRAR DATE: JUL 5 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6475

06436

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1520 EAST-WEST HIGHWAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 1520 EAST-WEST HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IDA; Middle McINTOSH; Last BOONE
4. DATE OF DEATH: Month JUNE; Day 15; Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN. 13, 1883
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): registered nurse - retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN A. McINTOSH
14. MOTHER'S MAIDEN NAME: JANE CARLOS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss Minnie B. McIntosh, Address: 1520 East-West Highway Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 40 yrs
416X
DUE TO (b) Arteriosclerotic Heart Disease — 4 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Congestive Heart Failure — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 4200 Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1956 to June 15, 1957, that I last saw the deceased alive on June 15, 1957, and that death occurred at 5:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. Curry M.D. ADDRESS (Street, city or town, state): 10620 Georgia Ave Silver Spring Md. DATE SIGNED: 6/15/57
PHYSICIAN'S NAME (Type): JOHN J. CURRY

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 6/16/57
22c. NAME OF CEMETERY OR CREMATORY: FOREST HILL CEMETERY
22d. LOCATION (City, town, or county) (State): MEMPHIS, TENNESSEE
23. FUNERAL DIRECTOR'S SIGNATURE: Warner & Humphrey, ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 6/17/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6437

06437

CERTIFICATE OF DEATH

Reg. Dist. No. 773

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4½ Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt 16232
d. STREET ADDRESS: 6 E. Ridge Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Jeffrey — Middle: Beacham — Last: Breasbears

4. DATE OF DEATH: Month: 6 — Day: 14 — Year: 1957

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10-9-55

9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None - Infant

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Royal Dolan Breasbears

14. MOTHER'S MAIDEN NAME: Vera Beacham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Viral Hepatitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
583X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/9, 1955, to 6/14, 1957, that I last saw the deceased alive on 6/14, 1957, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles Farwell M.D. — ADDRESS (Street, city or town, state): 12126 Vicks Hill Rd — DATE SIGNED: 6/14/57

PHYSICIAN'S NAME (Type): CHARLES FARWELL — Wheaton Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/15/57

22c. NAME OF CEMETERY OR CREMATORY: Unknown

22d. LOCATION (City, town, or county) (State): Kitty Hawk, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. M. Chambers — ADDRESS: 5801 Cherchland Ave Greenbelt Md

24a. REC'D BY REGISTRAR DATE: JUN 18 1957

24b. REGISTRAR'S SIGNATURE: J. Wilson Dodge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6476

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06438

Reg. Dist. No. 213

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Off Md. R-355, 1½ mi. W Clarksburg

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X-3
d. STREET ADDRESS: 507 Rossiter St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Carl Middle Ross Last Burke
4. DATE OF DEATH: Month 6/22/57 Day Year 19
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/10/~~27~~ 25
9. AGE (In years last birthday): 32 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pilot
10b. KIND OF BUSINESS OR INDUSTRY: Airline Transport
11. BIRTHPLACE (State or foreign country): Arizona
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Spencer A. Burke
14. MOTHER'S MAIDEN NAME: Mary E. Ross
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 567-26-0311
17. INFORMANT: Capital Airline Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Injuries, Extreme — INTERVAL BETWEEN ONSET AND DEATH: sudden
861X
DUE TO (b): Body & Extremities badly Mutilated
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Airplane Accident
20c. TIME OF INJURY: Hour 9:00 a.m. p.m. Month, Day, Year 6/22/57
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Country
20f. (City or town) (County) (State): Clarksburg Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/22/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 25, 1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Ft. Myer, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Everly Funeral Home By [signature]
ADDRESS: Mgr. Fairfax, Va.
24a. RECEIVED BY REGISTRAR: DATE JUN 26 1957
24b. REGISTRAR'S SIGNATURE: Lenwell Hughes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6477 **CERTIFICATE OF DEATH** 06439

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 704 McNeil Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING
d. STREET ADDRESS 704 McNeil Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ISAAC Middle RAYMOND Last BURTON
4. DATE OF DEATH Month JUNE Day 24 Year 1957
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/9/86
9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route man (retired)
10b. KIND OF BUSINESS OR INDUSTRY Congress Laundry
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WALTER T. BURTON
14. MOTHER'S MAIDEN NAME EDNA A. ATHINSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 578-24-7819
17. INFORMANT Mrs. Elsie M. Burton, 704 McNeil Rd. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rupture of aneurysm of abdominal aorta — INTERVAL BETWEEN ONSET AND DEATH: Immediate
451 X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
434.3 Cardiac decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1952, to 6/24, 1957, that I last saw the deceased alive on 1/22, 1957, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William D. Aud M.D. ADDRESS (Street, city or town, state) 906 Colesville Rd Silver Spring Md DATE SIGNED 6/24/57

PHYSICIAN'S NAME (Type) William D. Aud

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 6/26/57
22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE CEMETERY
22d. LOCATION (City, town, or county) BURTONSVILLE, MARYLAND (State)

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE 6/30/57
24b. REGISTRAR'S SIGNATURE Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6478

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06440

Item 14 FilmG216 6-13-57 et

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~8615 Brandt St.~~

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X 2 Bethesda
d. STREET ADDRESS: 8615 Brandt St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Duncan; Middle: Cameron; Last: Campbell

4. DATE OF DEATH: Month: June; Day: 6; Year: 1957 (19)

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 7/25/1887

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Exect. officer retired

10b. KIND OF BUSINESS OR INDUSTRY: F.H.A.

11. BIRTHPLACE (State or foreign country): Pa,

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James L. Campbell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Rose Campbell — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Carbon monoxide Poisoning
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

973.1

INTERVAL BETWEEN ONSET AND DEATH: Found dead in car at home

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in car in closed garage at home

20c. TIME OF INJURY Hour ~~XXX~~ p. m. — Month, Day, Year: 6/6/57

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart
DATE SIGNED: 6/6/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 6-7-57
22c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
22d. LOCATION (City, town, or county) (State): Dauphin Co. Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-8-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6479 06441

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beth esda
c. LENGTH OF STAY IN 1b: 9 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 16, 15 X-1
d. STREET ADDRESS: 5117 Westridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosa — Middle: Lee — Last: Canada
4. DATE OF DEATH: Month: June — Day: 22 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 5, 1872
9. AGE (In years lost birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired.
10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE
11. BIRTHPLACE (State or foreign country): ARKANSAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JESSIE E MARTIN
14. MOTHER'S MAIDEN NAME: SARAH (UNKNOWN)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-05-2665
17. INFORMANT: JOE HICKS-SON — Address: WASH. DC 5117 Westridge RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) Anterior Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO
(b) Coronary Atherosclerosis — 10 years
DUE TO
(c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260x Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to June 22, 1957, that I last saw the deceased alive on June 22, 1957, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Michel M. Healy M.D. — ADDRESS (Street, city or town, state): Washington Clinic, Washington 15 — DATE SIGNED: June 22, 1957

PHYSICIAN'S NAME (Type): Michel M. Healy

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 6-23-57
22c. NAME OF CEMETERY OR CREMATORY: Roselawn Cemetery
22d. LOCATION (City, town, or county) (State): Pulaski, Arkansas

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Dunnybrug — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6438

06442

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 223

Items 8+9: G217 6/28/57

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
c. LENGTH OF STAY IN 1b: less 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San + Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 325 University Blvd. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JACOB Middle none Last CAPLON

4. DATE OF DEATH: Month 6 Day 17 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 4-9-1892

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Manager (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Wine + liquors

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Leon Caplan

14. MOTHER'S MAIDEN NAME: not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Not Known

17. INFORMANT: Son (Irving Caplon) Address: same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS.
420.1
DUE TO
(b) CORONARY THROMBOSIS + MYOCARDIAL INFARCTION — 24 HRS+
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/17, 1957, to 11:00 AM 6/19, 1957, that I last saw the deceased alive on 6/17, 1957, and that death occurred at 11:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold Sterling M.D. — ADDRESS (Street, city or town, state): 1352 UNIVERSITY LANE — DATE SIGNED

PHYSICIAN'S NAME (Type): HAROLD STERLING — HYATTSVILLE MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/19/57

22c. NAME OF CEMETERY OR CREMATORY: Adas Israel

22d. LOCATION (City, town, or county) (State): Washington DC

23. FUNERAL DIRECTOR'S SIGNATURE: B Dangnanty + Sons — ADDRESS: 3501-14th St

24a. REG'D BY REGISTRAR DATE 6/10/57

24b. REGISTRAR'S SIGNATURE: J Milton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6480

CERTIFICATE OF DEATH

06443

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 130 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Prince William
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nokesville
d. STREET ADDRESS: R. D. 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

83X3

50

3. NAME OF DECEASED (Type or print): First: Clarence; Middle: Fitzwater; Last: Carrico

4. DATE OF DEATH: Month: June; Day: 1; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: February 28, 1925

9. AGE (In years lost birthday): 32 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Correctional Officer

10b. KIND OF BUSINESS OR INDUSTRY: Reformatory

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Henry Carrico

14. MOTHER'S MAIDEN NAME: Ada Angeline Fitzwater

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory paralysis — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b) metastatic choriocarcinoma — months
DUE TO
(c)

192X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 22, 1957, to June 1, 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S Weissman M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6-2-57
PHYSICIAN'S NAME (Type): SHERMAN WEISSMAN, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 4 1957
22c. NAME OF CEMETERY OR CREMATORY: Stonewall Memory Gardens
22d. LOCATION (City, town, or county) (State): Manassas, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: F Gaithersons
ADDRESS: Hyattsville Md
24a. REC'D BY REGISTRAR DATE: JUN 6 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6481

CERTIFICATE OF DEATH

06444

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural) — c. LENGTH OF STAY IN 1b: 36 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x 2 Chevy Chase
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital	d. STREET ADDRESS: 1 4 Magnolia Parkway — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Floyd	James	CARTER	June	19	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		February 7, 1893	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chiropractor	Chiropractic Physiotherapy	North Dakota	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George C. CARTER	Annabelle RHODES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW I	213-38-1365	Wife, Elsie Beatrice CARTER	(Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	5 to 6 weeks
DUE TO (b)	Arteriosclerotic Heart Disease	Indefinite
DUE TO (c)	Arteriosclerosis, generalized	Indefinite

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 14, 1957, to June 19, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 8:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas R. Ulshafer M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-19-57

PHYSICIAN'S NAME (Type): Thomas R. ULSHAFER, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	6-21-57	Arlington Nat'l Cemetery	Arlington	Virginia

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R.A. Pumphrey	R.A. Pumphrey, 7557 Wisc. Ave., Bethesda, Md.	6-19-57	Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6482

CERTIFICATE OF DEATH

06445
212
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville, R.F.D.
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Matthews Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 4311-Argyle Terrace, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Haddie — Middle: Smith — Last: Chiswell
4. DATE OF DEATH: Month: June — Day: 3 — Year: 19 57
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 26-1885
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert Smith
14. MOTHER'S MAIDEN NAME: Katie Schwartz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Whitney Sweeney — Address: 4311 Argyl Terrace, Washington D.C.?

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
420.1
DUE TO (b) Hypertensive Arteriosclerotic Cardiovascular Disease — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 443X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1954, to 3 June, 1957, that I last saw the deceased alive on 3 June, 1957, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John M. Smith M.D. — ADDRESS (Street, city or town, state): RFD Boyd, Maryland — DATE SIGNED: 4 June 57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/5/57
22c. NAME OF CEMETERY OR CREMATORY: Monocacy
22d. LOCATION (City, town, or county) (State): Beallsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: William B Helton — ADDRESS: Barnesville, Md.
24a. REC'D BY REGISTRAR — DATE: 6/4/57
24b. REGISTRAR'S SIGNATURE: Charles W Elgin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6483

CERTIFICATE OF DEATH

06446

Reg. Dist. No. 215

M

51

I

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 14 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia — b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3

d. STREET ADDRESS: 4426 Volta Place, N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bladen — Middle: Dulany — Last: CLAGGETT, Jr.

4. DATE OF DEATH: Month: June — Day: 5 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 4, 1939

9. AGE (In years last birthday): 17 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Student

11. BIRTHPLACE (State or foreign country): Canal Zone

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Bladen Dulany CLAGGETT

14. MOTHER'S MAIDEN NAME: Rhea A. ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Father, Bladen D. CLAGGETT (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Brain tumor, basilar; type unknown — INTERVAL BETWEEN ONSET AND DEATH: 18 months

237X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 22, 1957, to June 5, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 2:52 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Burt C. Johnson M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-7-57

PHYSICIAN'S NAME (Type): Burt C. Johnson, LCDR,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-10-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: Wash., D.C. — Joseph Gawler's & Sons, 1756 Pennsylvania Ave.,

24a. REC'D BY REGISTRAR: DATE 6-6-57

24b. REGISTRAR'S SIGNATURE: Mary B. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

Item 18 Film 217 7-5-57 ams

6460

06447

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): In auto at Old Montg. Co. Home

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 601 Anderson Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First: Julian — Middle: Keen — Last: Cochran

4. DATE OF DEATH: Month: 6 — Day: 18 — Year: 57 (19)

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/14/12

9. AGE (In years last birthday): 44 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

1

13. FATHER'S NAME: Levi W. Cochran

14. MOTHER'S MAIDEN NAME: Sarah Lewis

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-07-0955

17. INFORMANT: Mrs. A.F.Beane — Address: 129 S.Adams St. Rockville, Md.

0

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH:

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
Found dead in auto of his car

2

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Frank J. Broschart — 16 Russell Ave. Gaithersburg

DATE SIGNED: 6/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/20/57

22c. NAME OF CEMETERY OR CREMATORY: Rockville Union Cem.

22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 21 '57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6484

CERTIFICATE OF DEATH

06448

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3609 Lawrence Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Kensington
d. STREET ADDRESS: 1 3609 Lawrence Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORA Middle D. Last COCHRAN
4. DATE OF DEATH: Month June Day 24, Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/4/1892
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months 6 Days 20 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Joe Alexander Miller
14. MOTHER'S MAIDEN NAME: Nellie Holt Glover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-20-1916
17. INFORMANT: James L. Clark- Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
334x
DUE TO
(b) Hypostasis — 7 days
DUE TO
(c) Cerebral Arteriosclerosis — Many years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
522x Bed Patient for year

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1953 to June 24, 1957, that I last saw the deceased alive on June 24, 1957, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bradley D. Hodgkins M.D. ADDRESS (Street, city or town, state): 4413 Bradley Lane DATE SIGNED:

PHYSICIAN'S NAME (Type): Bradley D. Hodgkins-4413 Bradley Lane, Chevy Chase, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/27/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Prince Geo. Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 6-27-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6485

CERTIFICATE OF DEATH

Reg. Dist. No. 07581 2/6

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Garden San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookdale xo
d. STREET ADDRESS: 4608 Overbrook Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Frances; Middle: ; Last: Columbus

4. DATE OF DEATH: Month: June; Day: 28; Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 28, 1867
9. AGE (In years lost birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales lady
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wash. D.C
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Grant Mickum
14. MOTHER'S MAIDEN NAME: Eliza Jane Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Paul L. Doerr — Address: 4608 Overbrook Rd - Brookdale Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Acute — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
332X
DUE TO (b) Arteriosclerosis, severe, generalized — 5 yrs +
DUE TO (c) Advanced senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not ~~while~~ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9.27.56, to June 28, 1957, that I last saw the deceased alive on June 27, 1957, and that death occurred at 5:00 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Clapp M.D. — ADDRESS (Street, city or town, state): 3921 Ingomar St NW. Wash 15 DC — DATE SIGNED: 6.28.57

PHYSICIAN'S NAME (Type): Stewart Clapp

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-1-57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivert Cem.
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm J Lee & Sons — ADDRESS: 300 4th St N.E. Wash DC
24a. REC'D BY REGISTRAR DATE: 7-3-57
24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 attached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

Cerebral Thrombosis, Acute 3 days
Arteriosclerosis, severe, generalized 5 yrs +
Advanced senility

---

p. 27 St. June 27 57

June 27 57

Stewart Gilpin

Stewart Gilpin

Inspector of Vital Statistics

U.S. Dept. of Health, Education and Welfare

BUREAU V. S.

RECEIVED

JUN 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6436 **CERTIFICATE OF DEATH** Reg. Dist. No. 06449 2/6

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 302 Adelaide Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruby Middle: Louise Last: Conard
4. DATE OF DEATH: Month: June Day: 22 Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/19/87
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Loudon County, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Edward S. Benjamin
14. MOTHER'S MAIDEN NAME: Mary Etta Hardy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Louise Towles Address: 302 Adelaide Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

420.1

DUE TO (b) Essential Hypertension — 4 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 444X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT., 1953 to JUNE 22 1957 that I last saw the deceased alive on JUNE 22, 1957, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo M. Curtis M.D. ADDRESS (Street, city or town, state): 8218 Wisconsin Ave. DATE SIGNED: 6/22/57

PHYSICIAN'S NAME (Type): Leo M. Curtis Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/25/57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Washington 18, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond L. Moore ADDRESS: Arlington Funeral Home 3901 North Fairfax Drive Arlington, Virginia
24a. REC'D BY REGISTRAR DATE: JUN 25 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6487 **CERTIFICATE OF DEATH** 06450

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Bethesda
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Floyd; Middle Wallace; Last CREGLOW

4. DATE OF DEATH: Month June; Day 4; Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 17, 1908

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months 2; Days 17

IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electric Tec.

10b. KIND OF BUSINESS OR INDUSTRY: Bureau of Stand.

11. BIRTHPLACE (State or foreign country): Minnisota

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: George B. Creglow

14. MOTHER'S MAIDEN NAME: Mary Luther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Dr. A. J. Janes — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Hepatic Flexure of Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
153X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 211X
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple Polyposis of Colon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 3, 1957, to June 4, 1957, that I last saw the deceased alive on June 4, 1957, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur F. Woodward M.D. — ADDRESS (Street, city or town, state): Rockville, Md. — DATE SIGNED: 6/4/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 6/7/57

22c. NAME OF CEMETERY OR CREMATORY: Beneden Cemetery

22d. LOCATION (City, town, or county) (State): Bridgeprot, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE 6/8/57

24b. REGISTRAR'S SIGNATURE: Bertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

C

51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6488

CERTIFICATE OF DEATH

Reg. Dist. No. 016451

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 83 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Wisconsin~~ Maryland
b. COUNTY: ~~xxxxxxxx~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Nausau~~ ~~Patuxent River~~ 86X-3
d. STREET ADDRESS: 523 Park Avenue ~~MOQ 938-B, U.S. Naval Air Station~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Suann — Middle: Marie — Last: CRONK

4. DATE OF DEATH: Month: June — Day: 3 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 12, 1957

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months 2, Days 22; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Robert Ray CRONK

14. MOTHER'S MAIDEN NAME: Carole KAAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): ~~~~~~

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert R. CRONK (Father) — Address: (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH: 2 mos 22 days
752X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from May 12, 1957, to June 3, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 9:50P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George J. A. Magnant M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-4-57

PHYSICIAN'S NAME (Type): George J.A. MAGNANT, LT, MC, USN/U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-7-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 6-5-57

24b. REGISTRAR'S SIGNATURE: Mary C. Farrelly

2050272X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06452

6489

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5218 Edgemore Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: ; Last: Crosser
4. DATE OF DEATH: Month 6; Day 3; Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-7-1874
9. AGE (In years lost birthday): 82 yrs. — IF UNDER 1 YEAR: Months 11, Days 26 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House of Representatives
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? U.S. ~~yes~~
13. FATHER'S NAME: James Crosser
14. MOTHER'S MAIDEN NAME: Barbara Hogg
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert Crosser — Address: 5218 Edgemore Lane Beth. 14 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Decompensation and congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 17 days
433.1
DUE TO
(b) Auricular & ventricular fibrillation
~~DUE TO~~
(c) and Myocarditis — 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
422.2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1956, to 3 June, 1957, that I last saw the deceased alive on 2 June, 1957, and that death occurred at 3:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert Martyn Jr. M.D. — ADDRESS (Street, city or town, state): 5029 Bethesda Ave. — DATE SIGNED: 3 June 57

PHYSICIAN'S NAME (Type): HERBERT MARTYN JR

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 6/5/57
22c. NAME OF CEMETERY OR CREMATORY: Highland Park
22d. LOCATION (City, town, or county) (State): Clevelenad, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey Bethesda, Maryland
24a. REC'D BY REGISTRAR — DATE: 6/4/57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6439 **CERTIFICATE OF DEATH** Reg. Dist. No. 06453

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6709 Gude Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
d. STREET ADDRESS: 6709 Gude Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Weston Middle LeRoy Last Cryer
4. DATE OF DEATH: Month June Day 3 Year 1957
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/13/1899
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Eng. Safeway Store
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Cryer
14. MOTHER'S MAIDEN NAME: ~~unobtainable~~ -- Pittman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Betty Cryer Address: 6709 Gude Ave.,Takoma Pk,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Acute
420.1
DUE TO (b) Hypertension, old Cerebro-Vascular Accident — 4 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 331x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County), (State)

21. I certify that I attended the deceased from April 26, 1953, to June 3, 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 7 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest A. Sarao M.D. ADDRESS (Street, city or town, state): 7006 New Hampshire Ave DATE SIGNED: 6/3/57

PHYSICIAN'S NAME (Type): Ernest A. Sarao

22a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~
22b. DATE THEREOF: 6/7/57
22c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Pr.Geo.Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., ADDRESS: 2901 14thSt. N.W. Wash, D.C.
24a. REC'D BY REGISTRAR DATE: JUN 6 1957
24b. REGISTRAR'S SIGNATURE: J. Nelson Dell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06454

6490

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
c. LENGTH OF STAY IN 1b: 5days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): University Park 16 X 12
d. STREET ADDRESS: 4319 Van Buren Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine; Middle: ; Last: Cumberland

4. DATE OF DEATH: Month: June; Day: 12th; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 6th, 1866

9. AGE (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Thomas Cumberland

14. MOTHER'S MAIDEN NAME: Mary Bannister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs John Orspada — Address: Same d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 15 years
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1957, to June 12, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 7 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. ADDRESS (Street, city or town, state): Damascus, Md. DATE SIGNED: 6/12/57

PHYSICIAN'S NAME (Type): James P. Kerr — Damascus, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-15-1957

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Mattingly — ADDRESS: 131-11th St. S.W. Wash. D.C.

24a. REC'D BY REGISTRAR DATE: JUN 14 1957

24b. REGISTRAR'S SIGNATURE: Alberta G. Cooke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6491

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06455

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seneca
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 508 Denham Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: William — Last: CURTIS, Jr.

4. DATE OF DEATH: Month: June — Day: 15 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 20, 1942

9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months: 8 — Days: 25
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Curtis, Sr.
14. MOTHER'S MAIDEN NAME: Mildred L. Harding

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Geo. W. Curtis, Sr. - Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: sudden
929.8
DUE TO (b): Drowning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowned while swimming in Potomac River
20c. TIME OF INJURY Hour: 1:10 p. m. Month, Day, Year: 6/15/57
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac river
20f. (City or town): Seneca (County): Montgomery (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart, M. D.
DATE SIGNED: June 15, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 18, 1957
22c. NAME OF CEMETERY OR CREMATORY: Darnestown
22d. LOCATION (City, town, or county) (State): Darnestown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: JUN 19 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6492 Items 15,16 Film 0217 7-12-57 et 06456

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7911 Kentbury Drive

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bethesda
d. STREET ADDRESS: ~~7911 Kentbury Drive~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BARENT Middle HOILES Last De NIKE
4. DATE OF DEATH: Month June Day 17 Year 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26, 1936
9. AGE (In years last birthday): 21 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: J. Harold DeNike
14. MOTHER'S MAIDEN NAME: Alice Hoiles
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Army No (If yes, give war or dates of service): Aug. '55-May '56 None
16. SOCIAL SECURITY NO.: 101-28-1738
17. INFORMANT: Father- Item # 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thoracic Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Crushed Chest
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

979x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left Arm practically amputated at shoulder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Threw self in front of approaching Freight Train
20c. TIME OF INJURY: Hour 4:20 p.m. Month, Day, Year 6/17/ 19 57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): B & O R.R.
20f. (City or town) Bethesda, (County) Montg. Co., (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/17/57
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur. - Transit
22b. DATE THEREOF: 6/18/57
22c. NAME OF CEMETERY OR CREMATORY: Montrose
22d. LOCATION (City, town, or county) (State): Bond County, Illinois

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6133

CERTIFICATE OF DEATH

Reg. Dist. No. 06457 27

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN THIS PLACE: 3 1/2 wks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sharon Chronic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Langley Park – Silver Spring
d. STREET ADDRESS: x2 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amanda — Middle: — Last: Dennis
4. DATE OF DEATH: Month: June — Day: 8 — Year: 1957
5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 9 1880
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rutland, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Thiele
14. MOTHER'S MAIDEN NAME: Sophia Blanker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry W. Stafford (Son) — Address: 5012 Mass Ave NW Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Cerebral Infarction — 8 weeks
DUE TO (c) Hypertensive Cardiovascular Disease — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

332X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 17, 1957, to June 8, 1957, that I last saw the deceased alive on June 8, 1957, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Boris Rabkin M.D. — ADDRESS (Street, city or town, state): 1019 University Boulevard Silver Spring — DATE SIGNED:
PHYSICIAN'S NAME (Type): BORIS RABKIN M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): B
22b. DATE THEREOF: 6-11-57
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill
22d. LOCATION (City, town, or county) (State): Wash. DC.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: 5406 Ill. Ave. DC
24a. REC'D BY REGISTRAR: DATE: JUN 11 1957
24b. REGISTRAR'S SIGNATURE: Gertrude Lawley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

JUN 14 1957

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06458

6494

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA, MD.
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5903 JARVIS LANE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - YORK SPRINGS
d. STREET ADDRESS: Rural Route 2 75 x -3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First THEKESA Middle CATHERINE Last DINSMORE

4. DATE OF DEATH: Month JUNE Day 5 Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: AMER. IND.
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: SEPT 1, 1888
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months 9 Days 4
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - -
11. BIRTHPLACE (State or foreign country): WISCONSIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (FIRST NAME NOT KNOWN) CONNOR
14. MOTHER'S MAIDEN NAME: (FIRST NAME NOT KNOWN) FINNETTE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 011-18-7278
17. INFORMANT - SON Address: LESTER H. DINSMORE 5903 JARVIS LA. BETHESDA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
331X
DUE TO
(b) ARTERIOSCLEROTIC CEREBRAL VASCULAR DISEASE. —
DUE TO
(c) CONGESTIVE HEART FAILURE DUE TO RHEUMATIC HEART DISEASE 2 WEEKS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
491X BRONCHOPNEUMONIA

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 27, 1957, to JUNE 5, 1957, that I last saw the deceased alive on JUNE 5, 1957, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph D. Connor, M.D. — ADDRESS (Street, city or town, state): 9600 OLD GEORGETOWN RD. — DATE SIGNED: 5 June 1957

PHYSICIAN'S NAME (Type): JOSEPH D. CONNOR — BETHESDA 14, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/10/1957
22c. NAME OF CEMETERY OR CREMATORY: St. Francis Xavier
22d. LOCATION (City, town, or county) (State): Adams Co. (Gettysburg) Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: 7557 Wis. Ave. Beth. Md.
24a. REC'D BY REGISTRAR DATE 6-6-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

- - - - - - - -

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6495

CERTIFICATE OF DEATH

Reg. Dist. No. 06459 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fairland Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x 2 Silver Spring (Rural)
d. STREET ADDRESS: Fairland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: O — Last: Porr

4. DATE OF DEATH: Month: 6 — Day: 16 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 5, 1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: James Fitzpatrick

14. MOTHER'S MAIDEN NAME: Catherine Cullen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Catherine M Ruppert — Address: Silver Spring Fairland Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arthritis — 4 yrs
DUE TO
(c)

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 725X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/11, 1956, to 6/16, 1957, that I last saw the deceased alive on 6/11, 1957, and that death occurred at 10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: P M Bird — M.D. — ADDRESS (Street, city or town, state): Sandy Spring Md — DATE SIGNED: 6/16/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/20/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Frank Geiers Sons Co — ADDRESS: 3605-14 St N W Wash D.C.

24a. REC'D BY REGISTRAR DATE: JUN 18 1957

24b. REGISTRAR'S SIGNATURE: Frances Fallon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6496

CERTIFICATE OF DEATH

06460

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wood Acres
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5604 Gloster Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Wood Acres
d. STREET ADDRESS: 1 5604 Gloster Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dwight Middle David Last Doty
4. DATE OF DEATH: Month June Day 5, Year 1957
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/10/1906
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY: Haley-Doty
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Doty
14. MOTHER'S MAIDEN NAME: Rose Reid
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Dorothy V. Doty - Address: 5604 Gloster Road, Wood Acres, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(b) generalized arteriosclerosis — 3 yrs
DUE TO
(c)

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug., 1947 to June 5, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Burns M.D. ADDRESS (Street, city or town, state): 915-19th St. N.W. DATE SIGNED: 6/5/57

PHYSICIAN'S NAME (Type): JAMES T. BURNS Wash. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/8/57
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: 2901 14th St., N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: JUN 10 '57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6497 **CERTIFICATE OF DEATH** 06462

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 9 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 409 Silver Spring Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 409 Silver Spring Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: S. Isaac Elder

4. DATE OF DEATH Month Day Year: June 15 19 57

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 10, 1869
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clergyman
10b. KIND OF BUSINESS OR INDUSTRY: Ministry
11. BIRTHPLACE (State or foreign country): Knoxville, Iowa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: S. Griffin Elder
14. MOTHER'S MAIDEN NAME: Nancy Ellen Brady

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mrs. Florian J. Yeager, 409 Silver Spring, Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week.
DUE TO
(b) Arteriosclerotic renal disease — 5 years
DUE TO
(c)

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 June, 19 57, to 15 June, 19 57, that I last saw the deceased alive on 15 June, 19 57, and that death occurred at 11 50 p.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Seruch T. Kimble M.D.
ADDRESS (Street, city or town, state): 929 Pershing Drive, Silver Spring, Md.
DATE SIGNED: 6/16/57

PHYSICIAN'S NAME (Type): Seruch T. Kimble

22a. BURIAL, CREMATION, REMOVAL (Specify): Transit-Burial
22b. DATE THEREOF: 6/19/57
22c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
22d. LOCATION (City, town, or county) (State): St. Joseph, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: Werner E. Pumphrey
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 6/17/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06463

6498

CERTIFICATE OF DEATH

Reg. Dist. No. 2 / 4

1. PLACE OF DEATH:
COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3711 Randolph Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 3711 Randolph Rd.

3. NAME OF DECEASED: (Type or Print) (First) Oscar (Middle) Maurice (Last) EISEN

4. DATE OF DEATH: (Month) 6 (Day) 15 (Year) 1957

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M
8. DATE OF BIRTH: 5-7-14
9. AGE last birthday 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY: Roofing Contractor
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Louis N. Eisen
14. MOTHER'S MAIDEN NAME: Sarah Edelman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: David T. Eisen, 2312 Washington Ave. Chevy Chase, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Thrombosis — 30 mins.
DUE TO
ANTECEDENT CAUSE (B)
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/15/57 19..., to 6/15/57 19..., that I last saw the deceased alive on ..., 19..., and that death occurred at 4:20 AM, from the causes and on the date stated above.

SIGNATURE M. D. Martin
ADDRESS 2322 Blueridge Ave., Silver Spring, Md
DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 6/16/1957
NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park
LOCATION (City, town, or county) (State) Falls Church, Va.

DATE REC'D BY LOCAL REGISTRAR 6-17-57
REGISTRAR'S SIGNATURE Frances Potter
24. FUNERAL DIRECTOR Goodberg Funeral Home
ADDRESS 2117-9 - NW

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499

CERTIFICATE OF DEATH

Reg. Dist. No. 06464 276

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 1 13202 Okinawa Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: XXXXX Grover; Middle: Stevenson; Last: Ennis

4. DATE OF DEATH: Month: June; Day: 22; Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/19/94
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairy Worker
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Prince William County, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George T. Ennis
14. MOTHER'S MAIDEN NAME: Roxy Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXXXXXXXX
16. SOCIAL SECURITY NO.: 229-34-3661
17. INFORMANT: Lena Pearson — Address: 13202 Okinawa Ave., Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarc — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Occlusion
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-22, 1957, to 6-22, 1957, that I last saw the deceased alive on 6-22, 1957, and that death occurred at 4:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jason Geiger M.D. — ADDRESS (Street, city or town, state): 931 Pershing Dr., Silver Spring, Md. — DATE SIGNED: 6-22-57

PHYSICIAN'S NAME (Type): JASON GEIGER — 931 Pershing Dr., Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/25/57
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6500

CERTIFICATE OF DEATH

06465

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 2 1/2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 800 Buckingham Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 129 Philadelphia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First VERNA Middle S. Last EVANS

4. DATE OF DEATH Month June Day 6 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept. 5, 1877
9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housemaker
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Penna
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME ? Baldwin
14. MOTHER'S MAIDEN NAME Ada Farabee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Hazel Reng, 29 Philadelphia Ave. T.P. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - Right Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

443 X

DUE TO (b) Hypertensive Heart Disease — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

331 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-5 Apr, 1957, to 6 June, 1957, that I last saw the deceased alive on 5 June, 1957, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE G B Queen M.D. ADDRESS (Street, city or town, state) 7112 Willow Ave DATE SIGNED 6 June

PHYSICIAN'S NAME (Type) G. B. QUEEN Takoma Park Md 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF June 6, 1957
22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery
22d. LOCATION (City, town, or county) Prince George Co. (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll Street D.C.
24a. REC'D BY REGISTRAR DATE JUN 7 1957
24b. REGISTRAR'S SIGNATURE Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6501

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06467

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, Md.
c. LENGTH OF STAY IN 1b: 2½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: 5429 Connecticut Ave NW. Wash DC
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wash. D.C.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

47X-3

3. NAME OF DECEASED (Type or print): First: Katie; Middle; Last: Feher
4. DATE OF DEATH: Month: June; Day: 22; Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: 3/17/82
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Yugoslavia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or date of service): None
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Wm. Thomson, Attorney, Address: Nat'l Press Bldg. Room 808 Wash 4, DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO
(b): Arteriosclerotic Heart Disease — 5 YRS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Pancreatitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

587.0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 52 to June 22 19 57, that I last saw the deceased alive on June 21 19 57, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert G. Angle M.D. — ADDRESS (Street, city or town, state): 5009 Del Ray Ave, Bethesda, Md. — DATE SIGNED: 6/22/57

PHYSICIAN'S NAME (Type): ROBERT G ANGLE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6-26-1957
22c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK
22d. LOCATION (City, town, or county) (State): WEBSTER ST. WASH, DC.

23. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co — ADDRESS: Wash D.C. 1400 Chapin St. — DATE
24a. REC'D BY REGISTRAR: JUN 25 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06468

CERTIFICATE OF DEATH

6440

Reg. Dist. No. 123

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
LENGTH OF STAY (In this place): 30 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Santitarium Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: D. C. — COUNTY: 00 40m
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
STREET ADDRESS (If rural give location): 425 Butternut N. W.

47X-3

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Fenton (Last)

4. DATE OF DEATH (Month) June (Day) 1, (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Single	8-1-70	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov. Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Gov. Retired
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William H. Fenton
14. MOTHER'S MAIDEN NAME: Cordelia Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hosp. Chart

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

175X IMMEDIATE CAUSE (A) Carcinoma of Ovaries, with Metastasis

ANTECEDENT CAUSE(S) DUE TO (B) to colonand to retrogentoneal lymph nodes — several months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 4, 1949, to June 1, 1957, that I last saw the deceased alive on May 31, 1957, and that death occurred at ..... M. from the causes and on the date stated above.

SIGNATURE: Lloyd L. Ball, M.D. — ADDRESS (Street, city, town, state): 7835 Eastern Ave Silver Spring Md — DATE SIGNED: June 2, 1957

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 6-4-57
NAME OF CEMETERY OR CREMATORY: Glenwood
LOCATION (City, town, or county): Washington (State): DC

24. REC'D BY REGISTRAR DATE: JUN 6 1957
REGISTRAR'S SIGNATURE: J. Wilson Lobb
25. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Ga. Ave. N. W. Wash. D. C.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6502

CERTIFICATE OF DEATH

06469

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 4Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 105 Tulip Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: June — Middle: Pauline — Last: Filsinger

4. DATE OF DEATH: Month: June — Day: 13 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 14-1927

9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months: — Days: 29 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beautition

10b. KIND OF BUSINESS OR INDUSTRY: Beauty Salon

11. BIRTHPLACE (State or foreign country): Zihlman. Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Abram Windfield

14. MOTHER'S MAIDEN NAME: Marion Downton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: George E Filsinger. Gaithersburg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asthma, Bronchial — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO (b) Acute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

241K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to June 13 1957, that I last saw the deceased alive on June 12, 1957, and that death occurred at 2 p. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D. — ADDRESS (Street, city or town, state): 26 N. Summit Ave. Gaithersburg, Md. — DATE SIGNED: 6-14-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-16-57

22c. NAME OF CEMETERY OR CREMATORY: Eckhard

22d. LOCATION (City, town, or county) (State): Eckhard Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hafer Funeral Home, Frostburg. Md

24a. REC'D BY REGISTRAR DATE: June 15-57

24b. REGISTRAR'S SIGNATURE: Alberta G. Coale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6441 **CERTIFICATE OF DEATH** Reg. Dist. No. 06470 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 39 minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park
d. STREET ADDRESS: 7209 Flower Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Girl; Middle: ; Last: Ford
4. DATE OF DEATH: Month: 6; Day: 6; Year: 1957

5. SEX: Girl
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/6/57
9. AGE (In years last birthday) yrs.; IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.: 39

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----
10b. KIND OF BUSINESS OR INDUSTRY: ----
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Charles Theodore Ford
14. MOTHER'S MAIDEN NAME: Mildred Jean Dentith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: mother; Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Internal hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH: 1
DUE TO
(b) Fetal malformation of the Brainstem — 2
DUE TO
(c)

753.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 756.2 Ascites - cirrhosis of liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/6, 1957, to 6/6, 1957, that I last saw the deceased alive on 6/6/57, 19, and that death occurred at 7:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: D.A. St. Martin M.D. ADDRESS (Street, city or town, state): 9820 Dameron Dr. Silver Spring, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): D.A. St. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6-16-57
22c. NAME OF CEMETERY OR CREMATORY: Washington San. & Hosp.
22d. LOCATION (City, town, or county) (State): Takoma Park 12, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Chas. A. Fox, Md. ADDRESS: Wash. San. & Hospital, Takoma Pk.
24a. REC'D BY REGISTRAR DATE: 6/10/57
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

2075222 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6503

06471

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 10306 Insley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

50

3. NAME OF DECEASED (Type or print): First: Arturo Middle: Vazquez Last: Fourzan
4. DATE OF DEATH: Month: June Day: 20, Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 1, 1955
9. AGE (In years last birthday): one yrs. IF UNDER 1 YEAR: Months: 11 Days: Hours: IF UNDER 24 HRS.: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Mexico
12. CITIZEN OF WHAT COUNTRY? Mexico

2

13. FATHER'S NAME: Oswaldo Fourzan
14. MOTHER'S MAIDEN NAME: Theresa Vazquez
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b) Pulmonary effusions; inflammations, Abd. Organomegaly — 3 weeks
DUE TO (c) Leukemia — 7 mos

204.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

532X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 20, 1957 to June 20, 1957 that I last saw the deceased alive on June 20, 1957, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William J. Pieper M.D.
ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland
DATE SIGNED: 6/20/57
PHYSICIAN'S NAME (Type): William J. Pieper, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 6/21/1957
22c. NAME OF CEMETERY OR CREMATORY: Panteon Jardin
22d. LOCATION (City, town, or county) (State): Mexico City, Mexico

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901 14th St., N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: JUN 21 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

11

SERVICIO EXTERIOR MEXICANO

No. -5- Derechos 50.00 M.N. D/s. 4.00

CERTIFICO: que el Sr. William J. Pieper
Médico Cirujano del Hospital
Naval de Bethesda, Estado de Maryland
es la autoridad competente para expedir
el certificado que antecede.

Washington, D. C. Junio 20 de 1957
P. O. del Embajador

R. Dominguez.
Romeo Domínguez C.
Secretario

EMBAJADA DE MEXICO
SECRETARIA DE RELACIONES EXTERIORES
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6594 **CERTIFICATE OF DEATH** Reg. Dist. No. 06472 215

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 4215 12th Road South
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura Middle: Virginia Last: FOX
4. DATE OF DEATH: Month: June Day: 18 Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 8, 1909
9. AGE (In years last birthday): 47 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Richard Henry YOUNG
14. MOTHER'S MAIDEN NAME: Elizabeth WAGNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - - - -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Husband, Wilmer Leroy FOX (Same as #2) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Chronic Glomerular Nephritis — 20+ yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 23, 1957, to June 18, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 3:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: T.S. Dunn Jr. M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 6-18-57

PHYSICIAN'S NAME (Type): T.S. DUNN, Jr., LT MC USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-21-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. R. Farrar ADDRESS: S.H. Hines, 2901 14th St., N.W., Washington, D.C.
24a. REC'D BY REGISTRAR DATE: 6-18-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6595

06473

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 2 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia — b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fredericksburg 83x.3

d. STREET ADDRESS: 1400 Kenmore Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bradford — Middle: Daniel — Last: FRANZMAN

4. DATE OF DEATH: Month: June — Day: 9 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 2, 1957

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 0 — Days: 7 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: August Daniel FRANZMAN

14. MOTHER'S MAIDEN NAME: Catherine STAIR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Father, August D. FRANZMAN (Same as #2) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): KERNICTERUS — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS

DUE TO (b):

770.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 7, 1957, to June 9, 1957, that I last saw the deceased alive on June 9, 1957, and that death occurred at 5:05 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel Shuptar M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-10-57

PHYSICIAN'S NAME (Type): Daniel SHUPTAR, LT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-13-57

22c. NAME OF CEMETERY OR CREMATORY: Private Cemetery

22d. LOCATION (City, town, or county) (State): Evansville, Indiana

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey — ADDRESS: 7557 Wisc. Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 6-10-57

24b. REGISTRAR'S SIGNATURE: Mary C. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

9 V V V V V V X V V

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 6506 Item 7 FilmG217 7-1-57 et

06474

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CARROLL HALL Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1228 Eye St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MYRTLE Middle S. Last GABLE
4. DATE OF DEATH: Month 6 Day 25 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 11-1878
9. AGE (In years lost birthday): 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): IOWA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter E. Slaughter
14. MOTHER'S MAIDEN NAME: Margaret Hays
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: son — Address: Lewis M. Gable 1225 Park Ave..N.Y.,N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a): CEREBRAL HEMORRHAGE
443X
DUE TO
(b) HYPERTENSIVE HEART DISEASE
DUE TO
(c) ESSENTIAL HYPERTENSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
331X GENERALIZED ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 13, 1956, to 6-25, 1957, that I last saw the deceased alive on 6-25, 1957, and that death occurred at 1:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 5206 Norway St. Chevy Chase, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. ~~BURIAL, CREMATION,~~ REMOVAL (Specify): Removal
22b. DATE THEREOF: 6/26/57
22c. NAME OF CEMETERY OR CREMATORY: Wagner Asso.Cemetery
22d. LOCATION (City, town, or county) (State): Wagner, S. D.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,2901 14th St.N.W. — ADDRESS: Wash, D.C.
24a. REC'D BY REGISTRAR — DATE: JUN 27 1957
24b. REGISTRAR'S SIGNATURE: Frances Pottery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

JUN 27 1957

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 6507

06475

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b: 53 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 3612 Park Place, N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: (No Middle Name) — Last: Gabriel

4. DATE OF DEATH: Month: June — Day: 9 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negroid

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 27, 1909

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Gabriel

14. MOTHER'S MAIDEN NAME: Agnes Knox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	Three weeks
DUE TO		
(b)	Obstructive uropathy	At least 2½ months
DUE TO		
(c)	Carcinoma of the cervix uteri	One year.

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 17, 1957, to June 9, 1957, that I last saw the deceased alive on June 9, 1957, and that death occurred at 6:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin E. Liebling M.D. M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 6/10/57

PHYSICIAN'S NAME (Type): Martin E. Liebling, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): 6/13/57

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: LINCOLN MEM

22d. LOCATION (City, town, or county) (State): MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Frazier Funeral Home

ADDRESS: 389 R. I. Avenue

24a. REC'D BY REGISTRAR DATE: JUN 12 1957

24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6508

06476 24

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rear of Fred & Harry's Restaurant

d. STREET ADDRESS 104 Williamsburg Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ROLAND Middle WILLIS Last GARNER

4. DATE OF DEATH Month JUNE Day 25 Year 1957

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9/6/98

9. AGE (In years last birthday) 58 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER and Bus Driver Instructor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIS H. GARNER

14. MOTHER'S MAIDEN NAME MELVIN WINDSTEAD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #1

16. SOCIAL SECURITY NO. 578-10-5567

17. INFORMANT Mrs. Ellen C. Wolfhope, Address 104 Williamsburg Drive Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH

782.4

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J. Broschart M.D.

EXAMINER'S NAME (Type) FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED 6/25/57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 6/27/57

22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Pumphrey, ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE 6/30/57

24b. REGISTRAR'S SIGNATURE Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06477

6509

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery — 8101 Piney Branch Road, Silver Spring, MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring

d. STREET ADDRESS: 8101 Piney Branch Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ivie Carole, Middle Barr, Last GRAEVES

4. DATE OF DEATH: Month June, Day 26, Year 1957

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 28 1940

9. AGE (In years last birthday): 16 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond B Graeves

14. MOTHER'S MAIDEN NAME: Vivian Allie Barr McGinn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Col Raymond B Graeves — Address 8101 Piney Br Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ependymoma 4th ventricle with metastasis

193X

DUE TO to subarachnoid

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1952, 19, to June 18, 1957, that I last saw the deceased alive on 18 June, 1957, and that death occurred at 12:50A M, from the causes and on the date stated above.

ACTUAL SIGNATURE George J. Hayes M.D. ADDRESS (Street, city or town, state) Med Cert of Reg 4906, 20 Mar 44 DATE SIGNED 6/26/57

PHYSICIAN'S NAME (Type) George J Hayes

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 6/28/57

22c. NAME OF CEMETERY OR CREMATORY: GEO. WASH. MEM. CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphreys, ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE 6/30/57

24b. REGISTRAR'S SIGNATURE Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6510

06478

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Asbury Methodist Home for the Aged, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Baltimore~~ Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Baltimore~~ Westminster 06272
d. STREET ADDRESS: ~~2204 Sandy Road~~ Eldersburg Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle — Last GRAF
4. DATE OF DEATH: Month June Day 14 Year 1957
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 12, 1871
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Henry Sebasian Rockensuess
14. MOTHER'S MAIDEN NAME: Mary Bartman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Asbury Methodist Home, Gaithersburg, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO (b) hypertension
DUE TO (c) cardiovascular disease hypertrophied heart

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-11, 1956, to 6-14, 1957, that I last saw the deceased alive on June 12, 1957, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah Elizabeth Glover M.D. — ADDRESS (Street, city or town, state): 4208 Anthony ST. Kensington Md — DATE SIGNED: 6-14-57

PHYSICIAN'S NAME (Type): Sarah Elizabeth Glover

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/17/57
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
22d. LOCATION (City, town, or county) (State): Pikesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Dickner & Sons — ADDRESS: Balto 17 Md
24a. REC'D BY REGISTRAR: DATE 6/25/57
24b. REGISTRAR'S SIGNATURE: Alonda P. Cook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6511

07613

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 6 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanatorium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington x2
d. STREET ADDRESS: 3000 McComas Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ned — Middle: [illegible] — Last: Merrill Green

4. DATE OF DEATH: Month: 6 — Day: 29 — Year: 57 (19)

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/10/1877
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Col
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army retired
11. BIRTHPLACE (State or foreign country): Kan.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nehemiah Green
14. MOTHER'S MAIDEN NAME: Mary Sturtevant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W W I
16. SOCIAL SECURITY NO.:
17. INFORMANT: San. Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: one day
782.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/29/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/2/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: 1756 Pennsylvania Ave NW, Washington, DC
24a. REC'D BY REGISTRAR: DATE 7/5/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6512

CERTIFICATE OF DEATH

06479

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Bethesda Chevy Chase
d. STREET ADDRESS: 1 3603 Dunlop Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith — Middle Miller — Last GREENLEE
4. DATE OF DEATH: Month June — Day 4 — Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-19-84
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Miller
14. MOTHER'S MAIDEN NAME: Elizabeth Farris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Daughter, Mrs. Elizabeth Oehmann — Address: (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anasarca — 2 wks.
DUE TO (b) Hypoalbuminemia — 2 yrs.
DUE TO (c) Cirrhosis, cause unknown — 15 yrs.

581.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 May, 1957, to 4 June, 19 57, that I last saw the deceased alive on 3 June, 19 57, and that death occurred at 4:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. U. Shilling M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-4-57

PHYSICIAN'S NAME (Type): Charles U. SHILLING, LT (MC) USN/U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-7-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: R. A. Pumphrey — ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md
24a. REC'D BY REGISTRAR: DATE 6-4-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

RECEIVED

JUN 6 1957

BUREAU V. S.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06480

6442

CERTIFICATE OF DEATH

Reg. Dist. No. 773

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Maryland
d. STREET ADDRESS: 12134 Viers Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle:; Last: Guthrie
4. DATE OF DEATH: Month 6; Day 10; Year 1957
5. SEX: Boy
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-10-57
9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): — Md.
12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME: Charles Marsh Guthrie
14. MOTHER'S MAIDEN NAME: Eleanor Stephanie Sheehy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No; (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M. Roelke, R.N. Address: Washington Sanitarium

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Erythro blastosis Fetalis — INTERVAL BETWEEN ONSET AND DEATH
770.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1957 to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Michael M. Dobridge M.D. ADDRESS (Street, city or town, state): 10620 Georgia Ave Silver Spring, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): Michael M. Dobridge, M. D. 10620 Georgia Avenue, Silver Sp ring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6-12-57
22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
22d. LOCATION (City, town, or county) (State): WASH. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon ADDRESS: 3831-GA. Ave. N.W.
24a. REC'D BY REGISTRAR DATE: JUN 17 1957
24b. REGISTRAR'S SIGNATURE: J. Nelson Dodds

2075314 XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65i3

CERTIFICATE OF DEATH

06481

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Austin — Middle Warner — Last Hammond
4. DATE OF DEATH: Month June — Day 20 — Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/13/98
9. AGE (In years lost birthday): 59 yrs. — IF UNDER 1 YEAR: Months 1, Days 7 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Government Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Otho Warner Hammond
14. MOTHER'S MAIDEN NAME: Lula Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
415X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1957, to June 20, 1957, that I last saw the deceased alive on June 20, 1957, and that death occurred at 6:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James V. Kerr M.D. — ADDRESS (Street, city or town, state): Damascus, Md. — DATE SIGNED: 6/20/57

PHYSICIAN'S NAME (Type): J. P. Kerr, M. D. — Damascus, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/20/1957
22c. NAME OF CEMETERY OR CREMATORY: Clarksburg Methodist
22d. LOCATION (City, town, or county) (State): Montgomery Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: JUN 24 1957
24b. REGISTRAR'S SIGNATURE: Gertrude Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6514

CERTIFICATE OF DEATH

06482

Reg. Dist. No. 218

M

1. PLACE OF DEATH
a. COUNTY: Montg
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
c. LENGTH OF STAY IN 1b: 85 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Nicholas Middle: Last: Harding
4. DATE OF DEATH: Month: June Day: 22 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 5 1872
9. AGE (In years lost birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miller
10b. KIND OF BUSINESS OR INDUSTRY: Letsky Milling Co.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Zachariah Harding
14. MOTHER'S MAIDEN NAME: Annie Boswell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Joseph A Wolf — Address: 4465 Harrison St Chevy Chase Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 14 days
334X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral arteriosclerosis — 2 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1957, to June 22, 1957, that I last saw the deceased alive on June 22, 1957, and that death occurred at 8:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Vernon E. Martens M.D. ADDRESS (Street, city or town, state): Germantown, Md. DATE SIGNED: 6-22-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-25-57
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery
22d. LOCATION (City, town, or county) (State): Gaithersburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Spurier. ADDRESS: Gaithersburg Md.
24a. REC'D BY REGISTRAR DATE: June 25-57
24b. REGISTRAR'S SIGNATURE: Charles G. Cooke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6515

CERTIFICATE OF DEATH

06483

Reg. Dist. No. 214

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2700 HARDY AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 2700 HARDY AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle EDNA Last HARDY
4. DATE OF DEATH: Month JUNE Day 17 Year 19 57
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/4/76
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK - Bureau of Engraving - U.S. Gov't.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. FRANCIS HARDY
14. MOTHER'S MAIDEN NAME: Mary E. Sheehy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Mrs. Beulah A. Clarke, 2700 Hardy Ave. ~~Silver Spring, Maryland~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Carcinoma breast c metastases abdomen — 2 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 5, 19 56, to June 17, 19 57, that I last saw the deceased alive on June 17, 19 57, and that death occurred at 5:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Patrick Jameson M.D. ADDRESS (Street, city or town, state): 12020 Georgia Silver Spring Md DATE SIGNED: 6/17/57

PHYSICIAN'S NAME (Type): PATRICK JAMESON

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/20/57
22c. NAME OF CEMETERY OR CREMATORY: ST. JOHN'S CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 6/20/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6516

CERTIFICATE OF DEATH

06484

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 4DAYS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47 X-3
d. STREET ADDRESS: 3701 CONN AVE NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

74

3. NAME OF DECEASED (Type or print): First JONATHAN Middle WATERS Last HASLUP
4. DATE OF DEATH: Month JUNE Day 24 Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC-5-1892
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: CONTRACTOR
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: GILBERT A. HASLUP
14. MOTHER'S MAIDEN NAME: ANNA TURNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: SISTER — Address: MRS DOROTHY STACKHOUSE, 3701 CONN. WASH-DC.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) Immediate cause: Acute Bronchopneumonia — Interval between onset and death: 6 days
422.2
DUE TO
(b) Ch. Pulmonary Emphysema — 10 yrs
DUE TO
(c) Ch. Myocardial Degeneration — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
491x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-12-, 1957, to 6-24-, 1957, that I last saw the deceased alive on 6-23-57, 19____, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew J. Betz M.D. — ADDRESS (Street, city or town, state): 5412 Colo. Ave N.W. — DATE SIGNED: 6-24-57

PHYSICIAN'S NAME (Type): Andrew J. Betz — Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6/26/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR: DATE JUN 25 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06485

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 435 Northwest Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington, D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47x3
d. STREET ADDRESS: 4801 Connecticut Avenue, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert E. Middle: Heater Last:
4. DATE OF DEATH: Month: June Day: 16 Year: 19 57

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/1/75
9. AGE (In years on last birthday): 81 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate
10b. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John P. Heater
14. MOTHER'S MAIDEN NAME: Matilda Wire

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Evelyn S. Heater, Address: 4801 Conn. Ave., N.W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage & laceration — INTERVAL BETWEEN ONSET AND DEATH: sudden
976X
DUE TO (b): Bullet wound through skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted bullet wound
20c. TIME OF INJURY: Hour: 6:25 a. m. p. m. Month, Day, Year: 6/16 19 57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Office
20f. (City or town): Silver Spring (County): Montgomery (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: June 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/18/57
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 6/20/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6518 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06486

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4400 Glen Ridge Rd

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bethesda
d. STREET ADDRESS: 4400 Glen Ridge Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lonnie — Middle: Clyde — Last: Heflin Jr
4. DATE OF DEATH: Month: June — Day: 2 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 8 1918
9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months: 7 — Days: 24 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales manager
10b. KIND OF BUSINESS OR INDUSTRY: Refrigeration Co.
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.C.
13. FATHER'S NAME: Lonnie C Heflin
14. MOTHER'S MAIDEN NAME: Juanita White
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 577-16-4607
17. INFORMANT: Shirley Heflin — Address: Same #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

054X

DUE TO (b) Edema of Larynx — 1 hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Fulminating Bacterial Infection — Few hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Edema Lungs

522X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Brosnahan M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-3-57

EXAMINER'S NAME (Type): FRANK J. BROSNAHAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/5/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE 6/4/57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6519

06487

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Dist. of Col. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3
d. STREET ADDRESS 5407 41st St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

74

3. NAME OF DECEASED (Type or print) First: Frances Middle: Bell Last: Henry
4. DATE OF DEATH Month: June Day: 9 Year: 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Dec. 23, 1889
9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Admin. Assistant
10b. KIND OF BUSINESS OR INDUSTRY Dept. of Interior
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph P. Fincham
14. MOTHER'S MAIDEN NAME Lilie Mitchell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Edith Henry Tufty Address Same as #2

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

465x

DUE TO (b) Multiple pulmonary emboli — 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 153x Metastatic Carcinoma from Carcinoma of Colon

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec., 1956, to 6-9, 1957, that I last saw the deceased alive on 6-9, 1957, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Russell M. Tilley, Jr. M.D. ADDRESS (Street, city or town, state) 4201-Mass Ave N.W. Wash. 16 D.C. DATE SIGNED 6-10-57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6/12/57
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.
22d. LOCATION (City, town, or county) (State) Woodlawn Va

23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home ADDRESS D.C.
24a. REC'D BY REGISTRAR DATE 6-18-57
24b. REGISTRAR'S SIGNATURE Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6443

CERTIFICATE OF DEATH

06488

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 mo. 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 16152
d. STREET ADDRESS: 911 Roy Rd. Hampshire
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hannah Middle: Elizabeth Last: Herder

4. DATE OF DEATH: Month: June Day: 18 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-22-81
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov't Employee
10b. KIND OF BUSINESS OR INDUSTRY: Gov't employee
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: William Hall
14. MOTHER'S MAIDEN NAME: Elizabeth Beach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Chart Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Acute.
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956, to June 18, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest A. Sarao M.D. — ADDRESS (Street, city or town, state): 7006 New Hampshire Ave — DATE SIGNED: 6/18/57

PHYSICIAN'S NAME (Type): ERNEST A. SARAO Takoma Park 12, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/21/1957
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEM.
22d. LOCATION (City, town, or county) (State): SUITLAND Pr Geo Co, MD

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers — ADDRESS: Co Cleveland Ave Md.
24a. REC'D BY REGISTRAR: JUN 24 1957 — DATE
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6520

CERTIFICATE OF DEATH

06489

Reg. Dist. No. 2/2

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville, X2

d. STREET ADDRESS: Rural 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marshall Middle: Last: Hersberger

4. DATE OF DEATH: Month: June Day: 23 Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March-22-1880

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months: 3 Days: 1 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Poolesville, Montg C, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aaron Bucher Hersberger

14. MOTHER'S MAIDEN NAME: ~~Edna Earle Hersberger~~ Esther (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Edna Earle Hersberger Address: Poolesville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

331X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 23

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May-23-, 1957, to June-23-, 1957, that I last saw the deceased alive on June-23-, 1957, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Miller M.D. ADDRESS (Street, city or town, state): 7-Brooks Ave. DATE SIGNED:

PHYSICIAN'S NAME (Type): WILLIAM C. MILLER Gaithersburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/26/57

22c. NAME OF CEMETERY OR CREMATORY: Monocacy

22d. LOCATION (City, town, or county) (State): Beallsville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton ADDRESS: Barnesville, Md

24a. REC'D BY REGISTRAR DATE: 6/25/57

24b. REGISTRAR'S SIGNATURE: Charles W. Elgin per DBG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06490

6521

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D C
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 2335 California St NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMELEEN Middle CARLISLE Last HILL

4. DATE OF DEATH: Month June Day 24 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 27, 1876
9. AGE (In years lost birthday): 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Carlisle
14. MOTHER'S MAIDEN NAME: Emeline Howe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marianna H. deBeers, 2335 Calif. St NW — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of colon c metastasis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
153X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1957, to June 24, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 3:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. — ADDRESS (Street, city or town, state): Sandy Spring Md — DATE SIGNED: 6/24/57

PHYSICIAN'S NAME (Type): A. D. BONIFANT — Sandy Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6/26/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons — ADDRESS: 1756 Pennsylvania Ave NW, Washington, DC
24a. REC'D BY REGISTRAR: DATE 6/26/57
24b. REGISTRAR'S SIGNATURE: Laurell Keagle per EC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6522 **CERTIFICATE OF DEATH** 06491

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Garden Sanitarium
90

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wash. 47X-3
d. STREET ADDRESS: 2800 Quebec St. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PAUL Middle: E. Last: HUETTNER
4. DATE OF DEATH: Month: June Day: 18 Year: 1957

5. SEX: Male
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-3-1870
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Geo Comp.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA
2

13. FATHER'S NAME: John Huettner
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louise C. Hager Daughter Address:
0

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
422.1
(b) Congestive heart failure — 4 days
DUE TO
(c) A.S.C.V.D. — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 491x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1957, to 6/18 1957, that I last saw the deceased alive on 6/18 1957, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles M. Weber Jr. M.D. ADDRESS (Street, city or town, state): DATE SIGNED:
PHYSICIAN'S NAME (Type):
1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/19/57
22c. NAME OF CEMETERY OR CREMATORY: J. Wm. Lees
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: J. William Lee Sr. ADDRESS: 300-4 E. St NE
24a. REC'D BY REGISTRAR DATE: 6-24-57
24b. REGISTRAR'S SIGNATURE: Bernice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6523

CERTIFICATE OF DEATH

06492

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: West Virginia b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 11 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Martinsburg 85 X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 211 Rockwell Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Larry Middle: Eugene Last: Hughes

4. DATE OF DEATH: Month: June Day: 25 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 24, 1942

9. AGE (In years last birthday): 15 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stacey Hughes

14. MOTHER'S MAIDEN NAME: Pearl Bivins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	pulmonary edema	hours
DUE TO (b)	Uremia	10 days
DUE TO (c)	acute Leukemia	3 mos

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 0

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) G

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 14, 1957, to June 25, 1957, that I last saw the deceased alive on 25 June, 1957, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Waldmann M.D.

ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland

DATE SIGNED: 6/26/57

PHYSICIAN'S NAME (Type): Thomas Waldmann, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/28/57

22c. NAME OF CEMETERY OR CREMATORY: Rosedale

22d. LOCATION (City, town, or county) (State): Martinsburg, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE 6-27-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Humphries

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6444

06493

CERTIFICATE OF DEATH

Reg. Dist. No. 7 X3

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK.
c. LENGTH OF STAY IN 1b: 2 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: OAKHAVEN CONV. HOME.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. b. COUNTY: ---
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: West Clifton Terrace, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Willis Middle F. Last HURD
4. DATE OF DEATH: Month June Day 17 Year 1957
5. SEX: Male
6. COLOR OR RACE: White.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/26/69
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - exec. SOUTHERN RLWY
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Levi J. HURD
14. MOTHER'S MAIDEN NAME: Letitia Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 718-10-5943
17. INFORMANT: SON. Willis L. Hurd Address 3716 Manor Road Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized, — INTERVAL BETWEEN ONSET AND DEATH years.
450.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JULY 9, 1954 to JUNE 17, 1957, that I last saw the deceased alive on JUNE 16, 1957, and that death occurred at 10 55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William F. Simpson, Jr. M.D. — ADDRESS (Street, city or town, state): 6216 Nth Ave NE. — DATE SIGNED: 6/17/57
PHYSICIAN'S NAME (Type): WILLIAM F. SIMPSON, JR. — Washington, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/19/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. ADDRESS: 2901 14th St., N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: JUN 19 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Leddy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6445 06494

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6613 Allegheny Ave.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park
d. STREET ADDRESS: 6613 Alle gheny Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Isaac Middle Wilhelm ~~Isaacson~~ Last ISAACSON
4. DATE OF DEATH: Month 6/28/57 Day Year 19
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/18/1886
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Sweeden
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Isaacson
14. MOTHER'S MAIDEN NAME: Not Available
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ilma S. Isaacon Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 6/28/57

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Transit Burial
22b. DATE THEREOF: 7/3/57
22c. NAME OF CEMETERY OR CREMATORY: Cherry Cemetery
22d. LOCATION (City, town, or county) (State): Cherry, Minnesota

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE 7/1/57
24b. REGISTRAR'S SIGNATURE: J. Milm Dodd

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6524

CERTIFICATE OF DEATH

Reg. Dist. No. 06495

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1. PLACE OF DEATH a. COUNTY: MonTG — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 3 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: DC — b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X-3

d. STREET ADDRESS: 3460 39th St, N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: CLARENCE — Middle: H. — Last: Jewell

4. DATE OF DEATH: Month: June — Day: 5 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-20-94

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maitre de

10b. KIND OF BUSINESS OR INDUSTRY: army navy Club

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Judson Jewell

14. MOTHER'S MAIDEN NAME: EMRETTA GRIFFIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Hospt Record.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

420.1

DUE TO (b) Acute Coronary occlusion — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-2-57, 1957, to 6-5-57, 19____, that I lost saw the deceased alive on 6-5-57, 1957, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Roger Kurtz, M.D. — ADDRESS (Street, city or town, state): 3724 Conn Ave. NW — DATE SIGNED: 6-5-57

PHYSICIAN'S NAME (Type): C. Roger Kurtz

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~: burial

22b. DATE THEREOF: 6/8/57

22c. NAME OF CEMETERY OR CREMATORY: National Mem. Park

22d. LOCATION (City, town, or county) (State): Fairfax Co., Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The S.H. Hines Co., 2901 14th St. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: 6/10/57

24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525 **CERTIFICATE OF DEATH** Reg. Dist. No. 06496 296

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 301 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Washington b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarkston 84 x-3
d. STREET ADDRESS: Route #1, Box 1-F
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helen Middle (No middle name) Last Johnson
4. DATE OF DEATH: Month June Day 3 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 April 1911
9. AGE (In years last birthday): 46 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Health Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul W. Johnson
14. MOTHER'S MAIDEN NAME: Lura Burdick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 574-10-2853
17. INFORMANT: The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anoxia
DUE TO
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Metastatic Carcinoma of Breast

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 3, 1956, to June 3, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 11.15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur J. Garceau M.D.
ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland
DATE SIGNED: 6/4/57
PHYSICIAN'S NAME (Type): Arthur J. Garceau, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 6/5/57
22c. NAME OF CEMETERY OR CREMATORY: Vineland, Cemetery
22d. LOCATION (City, town, or county) (State): Clarkston, Washington

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-6-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6526

CERTIFICATE OF DEATH

Reg. Dist. No. 06497

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9412 Flower Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 19412 Flower Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Kathryn Middle: Tabitha Last: Johnston
4. DATE OF DEATH: Month: June Day: 29 Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 18 Sept 1906
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher - Northwood & Blair High School
10b. KIND OF BUSINESS OR INDUSTRY: PENNSYLVANIA
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: US
13. FATHER'S NAME: Herbert A. Johnston
14. MOTHER'S MAIDEN NAME: Bessie T. Schroyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ~ (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 199-20-2981
17. INFORMANT: H. A. Johnston Address: 9412 Flower Ave. S. Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) Immediate cause: Coronary Artery Thrombosis — Interval between onset and death: 1-2 hrs
420.1
DUE TO
(b) Coronary Artery Sclerosis — 1 yr
DUE TO
(c) Generalized Arteriosclerosis — 4-5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity & hypercholesterolemia
450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1954, to 29 June, 1957, that I last saw the deceased alive on 25 June 1957, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Merton L. White M.D. ADDRESS (Street, city or town, state): 11134 Georgia Ave Sil Spr DATE SIGNED: 29 Jun 57

PHYSICIAN'S NAME (Type): MERTON L. WHITE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/2/57
22c. NAME OF CEMETERY OR CREMATORY: GEO. WASH. MEM. CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 6/30/57
24b. REGISTRAR'S SIGNATURE: Frances Totten

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6527 **CERTIFICATE OF DEATH** Reg. Dist. No. 216 06498

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9501 Colesville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lester Middle Earl Last Jones
4. DATE OF DEATH: Month June Day 2 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 14 May 1892
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Decorator
10b. KIND OF BUSINESS OR INDUSTRY: Unascertainable
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H. Jones
14. MOTHER'S MAIDEN NAME: Gertie Mertz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-26-2846
17. INFORMANT: The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) massive intrapulmonary hemorrhage & edema — 6 days
204.1
DUE TO
(b) acute myelogenous leukemia
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 13, 1957, to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 12:55 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William J. Pieper M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/2/57
PHYSICIAN'S NAME (Type): William J. Pieper, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JUNE 5-1957
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE: BAST FUNERAL HOME ADDRESS: BOONSBORO MD
24a. REC'D BY REGISTRAR DATE: JUN 5 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06499

6528

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4918 Aurora Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4918 Aurora Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cornelia Middle R. Last JOYCE

4. DATE OF DEATH: Month June Day 5, Year 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/20/1892

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William C. Roberts

14. MOTHER'S MAIDEN NAME: Jane A. Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Francis J. Manning — Address: 4918 Aurora Drive Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Prostate Metastasis, spine 170X — INTERVAL BETWEEN ONSET AND DEATH: 6-9 months
DUE TO (b) Congestive Heart Failure — 1 week
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/15/57, 19____, to 6/5/57, 19____, that I last saw the deceased alive on 6/5/57, 19____, and that death occurred at 4:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sam Allen MD M.D. — ADDRESS (Street, city or town, state): Kensington Md — DATE SIGNED: 6/5/57

PHYSICIAN'S NAME (Type): SAMUEL ALLEN MD

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 6/10/57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 2901 14th St., N.W.

24a. REC'D BY REGISTRAR — DATE: JUN 10 1957

24b. REGISTRAR'S SIGNATURE: Frances Talley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6529

CERTIFICATE OF DEATH

06500

Reg. Dist. No. 212

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Slidell
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rt. #2 Boyds, Maryland
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (Oliver) O; Middle GARFIELD; Last KEITH

4. DATE OF DEATH: Month June; Day 4; Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 10, 1880
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathen Keith
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs. Laura E. Keith Address: Boyds #2, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Malnutrition — 6 months.
DUE TO
(c) Secondary anemia — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatic hypertrophy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 1953, to 4 June, 1957, that I last saw the deceased alive on 3 June, 1957, and that death occurred at 9 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John S Fawcett M.D. — ADDRESS (Street, city or town, state): Damsville P.O. Boyd — DATE SIGNED: 6/4/57

PHYSICIAN'S NAME (Type): JOHN S. FAWCETT M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 7, '57
22c. NAME OF CEMETERY OR CREMATORY: Hyattstown Cem.
22d. LOCATION (City, town, or county) (State): Hyattstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Gloyd W. Barber — ADDRESS: Laytonsville Md.
24a. REC'D BY REGISTRAR DATE 6/7/57
24b. REGISTRAR'S SIGNATURE: Charles W. Elgin per DBS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6530

CERTIFICATE OF DEATH

06501

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3255 Patterson St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fannie; Middle: ----; Last: Keller
4. DATE OF DEATH: Month: June; Day: 18; Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 16, 1876
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Maggie Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Pauline Long 3255 Patterson St., Ch. Ch., D.C. Address: N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Terminal Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days.
442X
DUE TO
(b) Nephrosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Hypertensive Cardio-Vasular-Renal Disease — 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, to June 18, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 4:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Clapp M.D. ADDRESS (Street, city or town, state): 3921 Ingoman St. N.W. DATE SIGNED: 6-18-57
PHYSICIAN'S NAME (Type): Stewart Clapp Wash 15 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6/20/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901 14th St. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR DATE: JUN 19 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6531

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06502

Reg. Dist. No. 216

Item 11 Film 9217 7/3/57 ga

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 95
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor San. & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bethesda
d. STREET ADDRESS: 5506 Glenwood Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

3. NAME OF DECEASED (Type or print): First: Emma; Middle: B.; Last: Kelling

4. DATE OF DEATH: Month: June; Day: 19; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5-31-1879

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: 0; Days: 19
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Ret. Teacher

11. BIRTHPLACE (State or foreign country): ~~Germany~~ Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.

2

13. FATHER'S NAME: O.L. Walweber

14. MOTHER'S MAIDEN NAME: Sophia Klentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Marcia Weidenlopf — Address: 5506 Glenwood Rd. Bethesda - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebro-Vascular hemorrhage — 5 yrs.
DUE TO
(c): Generalized Arterio-Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 20, 1953, to June 19, 1957, that I last saw the deceased alive on June 19, 1957, and that death occurred at 10:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Merrill M. Cross M.D.
ADDRESS (Street, city or town, state): 5248 Georgia Ave. Silver Spring, Md.
DATE SIGNED: 6/19/57

PHYSICIAN'S NAME (Type): MERRILL M. CROSS M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 6/24/57
22c. NAME OF CEMETERY OR CREMATORY: Graceland Cemetery
22d. LOCATION (City, town, or county) (State): Chicago, Illinois

23. FUNERAL DIRECTOR'S SIGNATURE: Robert W. Humphrey
ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG217 7-12-57 et

6532

CERTIFICATE OF DEATH

06503

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Germantown, Md.
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Marylander Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12,408 Flack Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph F. Kelly; Middle; Last
4. DATE OF DEATH: Month: June; Day: 23; Year: 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 12, 1884 (1885)
9. AGE (In years last birthday): 73 (72) yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer (retired)
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Elmira, N. Y.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Michael J. Kelly
14. MOTHER'S MAIDEN NAME: Mary M. Hurley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Joseph M. Kelly, Address: 12408 Flack St., Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
(b) Arteriosclerosis — 1 year
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cachexia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 7, 1956, to 23 June, 1957, that I last saw the deceased alive on June 23, 1957, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Fawcett M.D. ADDRESS (Street, city or town, state): P.O. Boyd, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): JOHN G. FAWCETT MD

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL
22b. DATE THEREOF: 6/27/57
22c. NAME OF CEMETERY OR CREMATORY: ST. MARY'S CEMETERY
22d. LOCATION (City, town, or county) (State): HORSEHEAD, NEW YORK

23. FUNERAL DIRECTOR'S SIGNATURE: Warren E. Humphrey, ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: June 26-57
24b. REGISTRAR'S SIGNATURE: Albert G. Cole

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6533 **CERTIFICATE OF DEATH** Reg. Dist. No. 06594

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 87 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Florida b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pensacola 48 x - 3
d. STREET ADDRESS: 828 North K Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Christine Middle: (None) Last: Kennedy
4. DATE OF DEATH: Month: June Day: 22, Year: 19 57
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 17, 1929
9. AGE (In years last birthday): 28 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Unascertainable
14. MOTHER'S MAIDEN NAME: Unascertainable
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma / pancreatic — 1 yr
DUE TO (b) islet cells
DUE TO (c) metastatic adenocarcinoma of liver
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

157x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 27, 19 57, to June 22, 19 57, that I last saw the deceased alive on June 22, 19 57, and that death occurred at 7:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gurston Goldin M.D. ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED: 6/22/57

PHYSICIAN'S NAME (Type): GURSTON GOLDIN, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): ✓
22b. DATE THEREOF: 6.24-57
22c. NAME OF CEMETERY OR CREMATORY: Pensacola
22d. LOCATION (City, town, or county) (State): Fla

23. FUNERAL DIRECTOR'S SIGNATURE: Frazier's Funeral Home ADDRESS: 389 N
24a. REC'D BY REGISTRAR DATE: 6/24/57
24b. REGISTRAR'S SIGNATURE: Bernie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6446

CERTIFICATE OF DEATH

06505

Reg. Dist. No. 283

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 41 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-9
d. STREET ADDRESS: 5012 Arkansaw Ave. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: William; Middle: John; Last: Kessler
4. DATE OF DEATH: Month: 6; Day: 15; Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 2-29-92
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Govt. Employee
10b. KIND OF BUSINESS OR INDUSTRY: Bur. of Eng.
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Andrew Kessler
14. MOTHER'S MAIDEN NAME: Emilie Fender
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b) Hypertensive heart disease — 5 yrs
DUE TO (c) Essential hypertension — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 332x Recent cerebral thrombosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-4, 1957, to 6-15, 1957, that I last saw the deceased alive on 6-15, 1957, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel M. Bageant M.D. — ADDRESS (Street, city or town, state): Washington DC — DATE SIGNED: 6/15/57
PHYSICIAN'S NAME (Type): SAMUEL M. BAGEANT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-18-57
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill
22d. LOCATION (City, town, or county) (State): Washington DC

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Deal — ADDRESS: 4812 Ga. Ave NW.
24a. REC'D BY REGISTRAR: DATE JUN 20 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Ardy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6534

CERTIFICATE OF DEATH

06506

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE X2
d. STREET ADDRESS: 7100 MEADOW LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH Middle: L. Last: KETCHAM

4. DATE OF DEATH: Month: JUNE Day: 1 Year: 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 23-1900
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: 11 Days: 8
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD LUCAS
14. MOTHER'S MAIDEN NAME: EDITH GROVE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: A.C. KETCHAM Address: 7100 MEADOW LANE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
420.1
DUE TO
(b) Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Generalized Arteriosclerosis — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
260X Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 22, 1957, to June 1, 1957, that I last saw the deceased alive on May 31, 1957, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Sidney C. Cousins M.D. ADDRESS (Street, city or town, state): 3927 Longmont St Wash 15 DATE SIGNED: 6/2/57

PHYSICIAN'S NAME (Type): SIDNEY C. COUSINS Wash. 15

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/3/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 6/4/57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6535

CERTIFICATE OF DEATH

06507

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Olney
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel 16412
d. STREET ADDRESS: 914 Philip Powers Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bernard Middle Ashby Last Kilby

4. DATE OF DEATH: Month June Day 12 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 16 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: House painter
11. BIRTHPLACE (State or foreign country): Culpepper Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Kilby
14. MOTHER'S MAIDEN NAME: Josephine Doggett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Josephine Dixon Address: Laurel Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
491X
DUE TO (b) Myocarditis, Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteo arthritis
422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 18, 1957, to June 12 1957, that I last saw the deceased alive on 6/9/57, 19____, and that death occurred at 2:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Sandy Spring Md
DATE SIGNED: 6/12/57

PHYSICIAN'S NAME (Type): J. M. BIRD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/15/57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson
ADDRESS: Laurel, Md
24a. REC'D BY REGISTRAR DATE: JUN 18 1957
24b. REGISTRAR'S SIGNATURE: Gertrude Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6447

06508

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12 GRANT AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 12 GRANT AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First KATHERINE Middle C. Last KING

4. DATE OF DEATH: Month JUNE Day 23, Year 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC 3, 1893.

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. SECY US GOVT

10b. KIND OF BUSINESS OR INDUSTRY: US GOVT.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: JAMES R. KING

14. MOTHER'S MAIDEN NAME: ANNIE E. WALKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service: —

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. OLIVE T. DUNN, Address: 12 GRANT AVE. T.P. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO
(b) Hypertensive Cardiovascular disease — 16 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4.20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
44SX

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to June, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R Coleman MD M.D. ADDRESS (Street, city or town, state): 113 Carroll St NW Wash. DC DATE SIGNED: 6/23/57

PHYSICIAN'S NAME (Type): JAMES R. COLEMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JUNE 26, 1957

22c. NAME OF CEMETERY OR CREMATORY: ST. JOHN'S CEM.

22d. LOCATION (City, town, or county) (State): FOREST GLEN, Mont Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 354 Carroll St NW DC

24a. REC'D BY REGISTRAR DATE 6/25/57

24b. REGISTRAR'S SIGNATURE: J. Richmond [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6448

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06509 / 73

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 Min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. and Hosp.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Langley Park 16 x 22
d. STREET ADDRESS: 1355 Langley Way Apt. 101
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75

3. NAME OF DECEASED (Type or print): First Florence Middle Ann Last Koval
4. DATE OF DEATH: Month June Day 17 Year 1957
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/20/28
9. AGE (In years last birthday): 29 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): SOUTH DAKOTA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BERNARD CLANCY
14. MOTHER'S MAIDEN NAME: MARIE Quilty

0

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arsenic Poisoning — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

971.6

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Taken a quanity of Acme Weed Killer containing 42.5% arsenic
20c. TIME OF INJURY Hour 5.00 a. m. p. m. Month, Day, Year 6/17/57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Langley Pk. (County) P.G. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 6/17/57

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/21/57
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NALT
22d. LOCATION (City, town, or county) (State): ARLINGTON, VA.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. TALTAVULL ADDRESS: 3619-14th St N.W. WASH DC
24a. REC'D BY REGISTRAR DATE: JUN 19 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Sodly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6449 Item 1 Film 217 6-24-57 et

06510

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md.
c. LENGTH OF STAY IN 1b: 16 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 56
d. STREET ADDRESS: 923 Gabel Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Susan — Middle Lynn — Last Kuehling

4. DATE OF DEATH: Month 6 Day 15 Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/14/57
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours 16 Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robt. Edward Kuehling
14. MOTHER'S MAIDEN NAME: Margaret Chase

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity - meningocele -
751X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/14/57, 19____, to 6/15/57, 19____, that I last saw the deceased alive on 6/14/57, 19____, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: D St Martin M.D. ADDRESS (Street, city or town, state): 2322 Blueridge Ave. DATE SIGNED

PHYSICIAN'S NAME (Type): David St. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/17/57
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE 6/17/57
24b. REGISTRAR'S SIGNATURE: J Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2075221XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6536

CERTIFICATE OF DEATH

06511
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillandale Md
c. LENGTH OF STAY IN 1b 14 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1732 Overlook Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hillandale Md.
d. STREET ADDRESS 1732 Overlook Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: James Middle: Winfield Last: Lanham
4. DATE OF DEATH Month: June Day: 5, Year: 19 57.

5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct 17, 1859
9. AGE (In years last birthday) 97 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Collington Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Stephen Lanham
14. MOTHER'S MAIDEN NAME Mary Ellen Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Alme L Fisher Address 1732 Overlook Drive ~~Hillandale, Md.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Arteriosclerotic Heart Disease — 1 yrs.
DUE TO
(c) Senility.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
572.1 Diverticulosis of Colon.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957, to June 5, 1957, that I last saw the deceased alive on April 15, 1957, and that death occurred at 11:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE John R Curran M.D. ADDRESS (Street, city or town, state) 1801 Eye St N.W. Washington, 6, DC DATE SIGNED

PHYSICIAN'S NAME (Type) JOHN R CURRAN M.D. 1801 Eye St N.W. Washington 6, DC

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF June 8, 1957
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE JUN 10 1957
24b. REGISTRAR'S SIGNATURE M. W. Aldrich

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06512

6537

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83 x 3
d. STREET ADDRESS: 1508 North Kentucky Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Louise; Last: Larsh
4. DATE OF DEATH: Month: June; Day: 21; Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 26, 1917
9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Key Punch Operator
10b. KIND OF BUSINESS OR INDUSTRY: Unascertainable
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Manning
14. MOTHER'S MAIDEN NAME: Bessie Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Progressive debilitation — INTERVAL BETWEEN ONSET AND DEATH: 8 mo
DUE TO
(b) Metastatic Disease. — 20 mo.
DUE TO
(c) Carcinoma of Endometrium — ?

172x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 5, 1957, to June 21, 1957, that I last saw the deceased alive on June 21, 1957, and that death occurred at 4.45 A.M., from the couses and on the date stated above.

ACTUAL SIGNATURE: Clarence S. Weldon M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/21/57
PHYSICIAN'S NAME (Type): Clarence S. Weldon, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: June 25, 1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Joe Funeral Home, G. P. Lee
ADDRESS: 2847 Wilson Blvd., Arlington, Va.
24a. REC'D BY REGISTRAR DATE: 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6538

CERTIFICATE OF DEATH

Reg. Dist. No. 215 06513

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X-3
d. STREET ADDRESS: 4634 Taney Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

51

3. NAME OF DECEASED (Type or print): First Aubrey — Middle Travis — Last LEAVELL
4. DATE OF DEATH: Month June — Day 1 — Year 1957
5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 2, 1893
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Bowman B. LEAVELL
14. MOTHER'S MAIDEN NAME: Annie B. CLATTERBUCK
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Floyd W. LEAVELL — Address: Route 4, Culpeper, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure & pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b) Resection of thoracic esophagus — 8 days
DUE TO (c) Carcinoma of the esophagus — Symptoms for 5-6 months

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

4341

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1957, to June 1, 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 3:07 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert P. Dobbie M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-1-57

PHYSICIAN'S NAME (Type): Robert P. DOBBIE, M.D. — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-3-57
22c. NAME OF CEMETERY OR CREMATORY: National Cemetery
22d. LOCATION (City, town, or county) (State): Culpeper, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Geest Funeral Parlors, Culpeper, Virginia — ADDRESS: Geest by RCPerrell
24a. REC'D BY REGISTRAR: DATE 6-1-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6539

CERTIFICATE OF DEATH

Reg. Dist. No. 216 — 06514

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 22 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: CHEVY CHASE MD. — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 CHEVY CHASE
d. STREET ADDRESS: 4815 CHEVY CHASE DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: SUSAN — Middle: EVA — Last: LELAND

4. DATE OF DEATH: Month: JUNE — Day: 27 — Year: 19 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: NOV. 13 – 1890

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months: 7 — Days: 14
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: RICHARD T. BUTLER

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH HALL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578-38-7002

17. INFORMANT: Charles B. Redmond — Address: 10032 Woodhill Rd. Bethesda, Maryland — MRS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 3 min
DUE TO
(b) Toxemia — 6 mo
DUE TO
(c) Carcinomatosis advanced — 6 mo

199.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): absence of one kidney surgically removed

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAR. 19 57, to JUNE 27, 1957, that I last saw the deceased alive on JUNE 27, 19 57, and that death occurred at 1:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John O Robben M.D. — ADDRESS (Street, city or town, state): 7930 Georgia Ave Silver Spring Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): John O. Robben — 7930 Georgia Ave. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-1-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A Pumphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE 6-30-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MS A15 (4) SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6540 **CERTIFICATE OF DEATH** Reg. Dist. No. 06515 214

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ASHTON
c. LENGTH OF STAY IN 1b: 4 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ASHTON, COLESVILLE RD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-ASHTON X1
d. STREET ADDRESS: COLESVILLE RD 1
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First EUGENE Middle LYMAN Last LEMERLE
4. DATE OF DEATH: Month 6 Day 13 Year 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 12, 1864
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PHYSICIAN
10b. KIND OF BUSINESS OR INDUSTRY: MEDICINE
11. BIRTHPLACE (State or foreign country): WASH. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUGUSTUS EUGENE LEMERLE
14. MOTHER'S MAIDEN NAME: AIETTA MARR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: EUGENIE L. RIGGS, Address: ASHTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemiplegia Sept. — INTERVAL BETWEEN ONSET AND DEATH: 8 days
334X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bronchopneumonia — 6 days
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
491X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/5/57, 1957, to 6/13/57, 1957, that I last saw the deceased alive on 6/5/57, 1957, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. N. Bird M.D. ADDRESS (Street, city or town, state): Sandy Spring, Montgomery Co. Md. DATE SIGNED: 6/13/57

PHYSICIAN'S NAME (Type): J. N. BIRD

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 6/17/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler Sons ADDRESS: 1756 Pa. Ave., N.W. DC
24a. REC'D BY REGISTRAR DATE: JUN 17 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6450

CERTIFICATE OF DEATH

~~06516~~ 06516

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: 6 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 17

d. STREET ADDRESS: 105 Hodges Lane

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Colin Middle: Shaw Last: Lewis

4. DATE OF DEATH: Month: June Day: 3 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-12-84

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed

10b. KIND OF BUSINESS OR INDUSTRY: Dry Goods

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Lewis

14. MOTHER'S MAIDEN NAME: Eliza Horrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

491X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 350 Parkinsons Disease, Advanced

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 May, 1957, to 3 June, 1957, that I last saw the deceased alive on 2 June, 1957, and that death occurred at 2:35 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Queen M.D. ADDRESS (Street, city or town, state): 7112 Willow Ave Takoma Park, Md DATE SIGNED: 3 June 1957

PHYSICIAN'S NAME (Type): H. B. QUEEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Transit Burial

22b. DATE THEREOF: June 5, 1957

22c. NAME OF CEMETERY OR CREMATORY: Winter Park Cemetery

22d. LOCATION (City, town, or county) (State): Wilmington, North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St NW. DC.

24a. REC'D BY REGISTRAR DATE: JUN 9 - 1957

24b. REGISTRAR'S SIGNATURE: J. Wilm Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

6541
Items 8,9:G217 7-2-57 L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06517
Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3 yrs.1 Mo. X2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall San. 10231 Carroll Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3705 Dunlop Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NAN — Middle TRAVIS — Last LINGLEY

4. DATE OF DEATH: Month June — Day 23, — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: Dec. 27, ~~1883~~ 1888
9. AGE (In years last birthday): 68 ~~73~~ yrs.
IF UNDER 1 YEAR: Months 5 — Days 26
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Capital Transit
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Frank M. Travis
14. MOTHER'S MAIDEN NAME: Betty B. Collawn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son — Address: Louis C. Paladini 3705 Dunlop St. Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
(b) ACUTE MYOCARDITIS
DUE TO
(c) CHRONIC MYOCARDITIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CEREBRAL SCLEROSIS
334X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 23, 1954, to JUNE 23, 1957, that I last saw the deceased alive on JUNE 23, 1957, and that death occurred at 4:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry M. Lowden M.D. — ADDRESS (Street, city or town, state): 5206 Norway Dr. Chevy Chase, Md. — DATE SIGNED: 6/23/57
PHYSICIAN'S NAME (Type): Henry M. Lowden

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-26-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6542

CERTIFICATE OF DEATH

Reg. Dist. No. 06518 2/6

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8212 CUSTER RD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
d. STREET ADDRESS: 8212 CUSTER RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS Middle J Last MacKAVANAGH
4. DATE OF DEATH: Month 6 Day 4 Year 1957
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 25, 1882
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lawyer & Electrical Engineer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: James MacKavanagh
14. MOTHER'S MAIDEN NAME: Mary Coyle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 577-07-1543-A
17. INFORMANT: Rev. Kelgin J. MacKavanagh Address Geo.town Prep. School D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 10 minutes
420.1
DUE TO
(b) Generalized Arteriosclerosis — unk
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
450.0
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ ~~CAUSE OF DEATH~~ (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1955, to June 4, 1957, that I last saw the deceased alive on June 4, 1957, and that death occurred at 4:55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Willard Camalier, Jr. M.D. ADDRESS (Street, city or town, state): 1801-Eye St. N.W. DATE SIGNED: 6/4/57
PHYSICIAN'S NAME (Type): C. WILLARD CAMALIER, JR. Wash. 6, D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/6/57
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The S.H.Hines Co. Washington, D. C.
24a. REC'D BY REGISTRAR DATE: JUN 6 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6543

06519

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9810 Georgia Ave. Maple Lane Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-9
d. STREET ADDRESS: 1851 Columbia Rd.,N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Ryan Last: Marshall
4. DATE OF DEATH: Month: June Day: 26 Year: 1957
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 25,1877
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph N. Ryan
14. MOTHER'S MAIDEN NAME: Lucy F. McCormick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Arthur D.Yewell,6609 Oxton Road, Address Bethesda,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 da
442X
DUE TO
(b) cardio vascular renal disease — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
431X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 6, 1957 to June 26 1957 that I last saw the deceased alive on June 25, 1957, and that death occurred at 7:55 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: E.E. Quayle M.D.
ADDRESS (Street, city or town, state): DATE SIGNED: June 26 57
PHYSICIAN'S NAME (Type): E.E. Quayle 1822 Baltimore St NW Wash D.C.

22a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~
22b. DATE THEREOF: 6/29/57
22c. NAME OF CEMETERY OR CREMATORY: Old Chapel Cemetery
22d. LOCATION (City, town, or county) (State): Berryville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,2901 14th St. N.W. ADDRESS Wash., D.C.
24a. REC'D BY REGISTRAR DATE JUN 28 1957
24b. REGISTRAR'S SIGNATURE Frances Patter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

6544

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06520
273
Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Monty — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pot. R. - 1½ mi. above St. Jacks

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillcrest Dr. 16 X 2 d
d. STREET ADDRESS: 2531 Colebrooke Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Paxton Last: Mays Jr.
4. DATE OF DEATH: Month: June Day: 26 Year: 1957
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-9-1949
9. AGE (In years last birthday): 8 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Paxton Mays Sr
14. MOTHER'S MAIDEN NAME: Constance Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jas. R. Mays Sr - Same & 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): drowning
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Stepped into deep water while fishing
20c. TIME OF INJURY: Hour 3:25 p.m. Month, Day, Year 6/26 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac R
20f. (City or town): Potomac (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-26-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-27-57
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Charlottesville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 517-11th St. S.E.
24a. REC'D BY REGISTRAR DATE: JUN 28 1957
24b. REGISTRAR'S SIGNATURE: Russell Langton

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6545

06521

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York
b. COUNTY: Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Valatie 69X-3
d. STREET ADDRESS: Upper Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Virginia — Last: Mazal
4. DATE OF DEATH: Month: June — Day: 7th, — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 14th, 1920
9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Hand
10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Arthur Mazal
14. MOTHER'S MAIDEN NAME: Nellie Sitzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 074-14-9300
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Intracranial + intra abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
199.9
DUE TO (b) 2 mo to metastatic choriocarcinoma — 6/4 – 6/7
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Pulmonary metastases
Choriocarcinoma, status post panhysterectomy — 11/56 – 6/57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 31st, 1957, to June 7th, 1957, that I last saw the deceased alive on June 7th, 1957, and that death occurred at 6:25A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter D. Olch M.D.
ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/7/57
PHYSICIAN'S NAME (Type): Peter D. Olch, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 6/7/57
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn
22d. LOCATION (City, town, or county) (State): Niverville, New York

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-8-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED
JUN 11 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06522

6546

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 weeks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mrs. Green's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXON HILL
d. STREET ADDRESS: 5000 - Livingston Rd S.E.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First BENSON Middle P Last McDANIEL
4. DATE OF DEATH: Month JUNE Day 2 Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT. 16, 1875
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bank Guard
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Thomas McDaniel
14. MOTHER'S MAIDEN NAME: Not known.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ___ (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jane Cox — Address: 101 Salisbury Dr. S.E. Wash, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 4 Days.
DUE TO
(b): Cerebral Atherosclerosis — 5 years.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

337 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Congestive Heart Failure. 434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 12, 1957, to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 7:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. Roberts M.D. — ADDRESS (Street, city or town, state): 8907 Georgia Ave — DATE SIGNED: 6/2/57.
PHYSICIAN'S NAME (Type): JAMES A. ROBERTS M.D. SILVER SPRING, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-5-57
22c. NAME OF CEMETERY OR CREMATORY: Shiloh Meth. Cemetery
22d. LOCATION (City, town, or county) (State): Poomonkey Md
23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. — ADDRESS: 1661 - Good Hope Rd SE Wash D.C.
24a. REC'D BY REGISTRAR DATE: JUN 4 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6547

CERTIFICATE OF DEATH

06523

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 4 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Maryd
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park 18x22
d. STREET ADDRESS: 305 Wasp Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Mc Lain
4. DATE OF DEATH: Month: June — Day: 11 — Year: 19 57
5. SEX: Femmle
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/11/57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours 4 — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Henry McLain
14. MOTHER'S MAIDEN NAME: Shirley Louise Youngman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother — Address: Same #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asbestosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hr
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congenital prematurity - wt. 1-3 3/4
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/11, 1957, to 6/11, 1957, that I last saw the deceased alive on 6/11, 1957, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. — ADDRESS (Street, city or town, state): Sandy Spring, Md — DATE SIGNED: 6/14/57

PHYSICIAN'S NAME (Type): A. D. Bonifant, M. D. — Sandy Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: June 12, 1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Prince George's Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 6/14/57
24b. REGISTRAR'S SIGNATURE: Bernard B. Lawler

2073272XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451

CERTIFICATE OF DEATH

Reg. Dist. No. 06524 223

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 517 ALBANY AVENUE Oak Haven Conv. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PINEY POINT 18 x 22
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): XXXXXXXXXXXX First PHILIP Middle JACKSON Last MEDLEY
4. DATE OF DEATH: Month JUNE Day 10 Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/21/62
9. AGE (In years last birthday): 94 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - retired
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (State or foreign country): St. Mary's County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES MEDLEY
14. MOTHER'S MAIDEN NAME: LOUISA ALLSTON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. J. Ingram Medley, Address: 7840 Aberdeen Rd. Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3-4 day
492x
DUE TO (b) Infection Plus Inanition
DUE TO (c) Plus 94 yr of age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19____, to June 10, 1957, that I last saw the deceased alive on May 31, 1956, and that death occurred at 10:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H. Wolohon M.D. ADDRESS (Street, city or town, state): 5011 Underwood St. NW Wash. DC DATE SIGNED: 6/10/57

PHYSICIAN'S NAME (Type): Chas H. WoLOHON

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/13/57
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE 6/14/57
24b. REGISTRAR'S SIGNATURE: J. Nelson Scott

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6548

CERTIFICATE OF DEATH

06525

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 42 yrs x2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 19 - E. Lenox
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter Middle: Curran Last: Mendenhall
4. DATE OF DEATH: Month: June Day: 2, Year: 1957
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-20-1871
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director
10b. KIND OF BUSINESS OR INDUSTRY: Geological Survey
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm K. Mendenhall
14. MOTHER'S MAIDEN NAME: Emma Pierce
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Alice Mendenhall Address: 9 E. Lenox Ch. Ch. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (a) Hemorrhage from Gastro Intestinal Tract — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
153x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suspect Carcinoma Colon — —
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to June 2, 1957 that I last saw the deceased alive on June 2, 1957, and that death occurred at 3:40 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peyton R Evans Jr M.D. ADDRESS (Street, city or town, state): 5401 Western Ave N.W. DATE SIGNED: 6-3-57
PHYSICIAN'S NAME (Type): Peyton R. Evans Jr Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 6-4-57 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill 22d. LOCATION (City, town, or county): Suitland Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons ADDRESS: Wash. D.C.
24a. REC'D BY REGISTRAR DATE: 6-6-57 24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6549

CERTIFICATE OF DEATH

06526

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Chevy Chase) Washington 47x-3
d. STREET ADDRESS: 5201 Chevy Chase Parkway, NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Essie — Middle: Lucretia — Last: MICHAELIS

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 4 1880
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown (GISE)
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - -
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son, Joseph L. MICHAELIS — Address: Wheaton, Maryland 11906 Garner St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 6 days
420.0
DUE TO (b) Auricular Fibrillation — 4 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Arteriosclerotic Heart Disease — unk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
433.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 5, 1957, to June 10, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 9:58 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-11-57

PHYSICIAN'S NAME (Type): Thomas S. DUNN, Jr. LT MC USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-14-57
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
22d. LOCATION (City, town, or county) (State): Washington, Dist. of Columbia

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: J.W. Lee Sons, 4th & Mass. Ave., N.E., Wash., D.C.
24a. REC'D BY REGISTRAR: DATE 6-11-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06527

6452 **CERTIFICATE OF DEATH**

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington DC — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47x-3
d. STREET ADDRESS: 4421 48th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Axel — Middle: Conrad — Last: Millbrook
4. DATE OF DEATH: Month: June — Day: 30 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 5/3/1887
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Corson-Gruman)
10b. KIND OF BUSINESS OR INDUSTRY: Construction Engineer
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? Sweden

13. FATHER'S NAME: Axel M. Millbrook
14. MOTHER'S MAIDEN NAME: Anna Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs
600.0
DUE TO (b) Uremia — 30 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Chronic pyelonephritis — 1-2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/24 1957 to June 30 1957 that I last saw the deceased alive on June 30, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur J. Wilets M.D. — ADDRESS (Street, city or town, state): 909 Pershing Drive, Silver Spring — DATE SIGNED: 6/30/57

PHYSICIAN'S NAME (Type): Arthur J. Wilets

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/3/1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 1901-14th St. Wash. D. C. N.W.
24a. REC'D BY REGISTRAR: DATE 1/3/57
24b. REGISTRAR'S SIGNATURE: J. Willard Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13 Film 216 6-17-57 et

06528 Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10208 Fleming Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bethesda
d. STREET ADDRESS: 10208 Fleming Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Ray Last Millis
4. DATE OF DEATH: Month June Day 10 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-21-1899
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months 0 Days 19
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Capt Navy
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Agnes McKie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Florence Millis Address: Same #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-10-57
EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/13/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-11-57
24b. REGISTRAR'S SIGNATURE: Bernice M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6551 **CERTIFICATE OF DEATH** 06529

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 1 month 28 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Mont.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Chevy Chase

d. STREET ADDRESS: 4700 Bradley Boulevard

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Isabelle Last: MILSTEAD

4. DATE OF DEATH Month: June Day: 7 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 25, 1891

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Kenneth MORGAN

14. MOTHER'S MAIDEN NAME: Blanche R. PADGETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Husband, Wallace A. MILSTEAD (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand Mal Convulsions + inanition — INTERVAL BETWEEN ONSET AND DEATH

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Multiple Metastatic lesions from — indefinite

DUE TO (c) Carcinoma, uterus (endometrium) — 1½ yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 10, 1957, to June 7, 1957, that I last saw the deceased alive on June 7, 1957, and that death occurred at 4:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: George L. Johnson, M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 6-7-57

PHYSICIAN'S NAME (Type): George L. Johnson, Jr., LTMCUSN/U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-10-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md

24a. REC'D BY REGISTRAR DATE 6-7-57

24b. REGISTRAR'S SIGNATURE Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06530

6552

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Vermont b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 9 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Albans 82 X-3

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 135 Federal Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mena Middle Delma Last Miner

4. DATE OF DEATH: Month June Day 11, Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 9, 1930

9. AGE (In years last birthday): 26 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Vermont

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Paquette

14. MOTHER'S MAIDEN NAME: Stella Mercey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 008-20-6316

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Air Embolism — INTERVAL BETWEEN ONSET AND DEATH: 0

754.3

DUE TO (b) Open Heart Surgery. — 30 min

DUE TO (c) Congenital Heart disease Atrial Septal Defect — 26 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 1957, to June 11, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 12:29 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence S. Weldon M.D.

ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland

DATE SIGNED: 6/17/57

PHYSICIAN'S NAME (Type): Clarence E. Weldon, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 6/15/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

22d. LOCATION (City, town, or county) (State): St. Albans, Vermont

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 6-14-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6453

CERTIFICATE OF DEATH

06531

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47x-3
d. STREET ADDRESS: 1746 Lamont St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John, Middle Phillip, Last Morris

4. DATE OF DEATH: Month June, Day 26, Year 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 26, 1893
9. AGE (In years lost birthday): 63 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Green L. Morris
14. MOTHER'S MAIDEN NAME: Nancy Hodges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW #1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hugh Morris, Address: 3048 Oliver St., N. W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute auricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 36 hr
DUE TO (b) Beri Beri heart disease — 3 mo
DUE TO (c) Arteriosclerosis — generalized — 7

280 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 450 Malnutrition (severe).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-25, 1957, to 6-26, 1957, that I last saw the deceased alive on 6-26, 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E H Markwood M.D. — ADDRESS (Street, city or town, state): Wash. 10, D. C. — DATE SIGNED:

PHYSICIAN'S NAME (Type): E. H. Markwood, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 28, 1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Fort Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner & Humphrey, ADDRESS: Silver Spring, Md
24a. REC'D BY REGISTRAR DATE: 6/19/57
24b. REGISTRAR'S SIGNATURE: J. Atkinson Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

6553

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06532

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 Hour 10 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~XXXXXXXXXXX~~ KENSINGTON X 2
d. STREET ADDRESS: 3932 Washington St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Mary Avondale; Middle: ~~XXXXXX~~; Last: MOULDEN

4. DATE OF DEATH: Month: June; Day: 26; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: SEPT. 20, 1894

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland, Mont. County

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William V. Beall

14. MOTHER'S MAIDEN NAME: Mary E Purdum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Eleanor M. Cervenka, Address: 3932 Washington Street Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

4341

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type): FRANK J. Broschart
DATE SIGNED: 6-26-57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 6/29/57

22c. NAME OF CEMETERY OR CREMATORY: ROCKVILLE CEMETERY

22d. LOCATION (City, town, or county) (State): ROCKVILLE, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey, ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE 6-30-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6554 **CERTIFICATE OF DEATH** Reg. Dist. No. 06533 211

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodfield

c. LENGTH OF STAY IN 1b: IO Years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Woodfield

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gaithersburg R FD # I

d. STREET ADDRESS: Gaithersburg RFD # I

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle DAVID Last MOYER

4. DATE OF DEATH: Month JUNE Day II Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept, IO I877

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U,S,A,

13. FATHER'S NAME: Ambrose Moyer

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Stormback

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ######

16. SOCIAL SECURITY NO.: 217 32 I309

17. INFORMANT: Harriet M. Moyer, Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Day.

420.1

DUE TO (b) Arteriosclerotic cardiovascular disease — 10 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 11, 1957, to June 11, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE James P. Kerr M.D. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 6/12/57

PHYSICIAN'S NAME (Type) James P. Kerr Damascus Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June I4 57

22c. NAME OF CEMETERY OR CREMATORY: Ft, Lincoln

22d. LOCATION (City, town, or county) (State): Prince George Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W Barber ADDRESS: Laytonsville, Md,

24a. REC'D BY REGISTRAR DATE June 14/57

24b. REGISTRAR'S SIGNATURE: Della M Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6555 06534

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bethesda
d. STREET ADDRESS: 5148 Mass. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernadette Middle: M. Last: Mulqueen

4. DATE OF DEATH: Month: 6 Day: 6 Year: 19 57

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 6/~~10~~/~~55~~ 1900
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Cauley
14. MOTHER'S MAIDEN NAME: Mary Welch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp. Record Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration + hemorrhage Pons — INTERVAL BETWEEN ONSET AND DEATH: 4 days
900.0
DUE TO (b) Fall down stairs — 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): multiple lacerations cerebral cortex,

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell down stair steps at home
20c. TIME OF INJURY: 1:30 a. m. p. m. Month, Day, Year: 6/1/57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Bethesda (County): Montg (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/7/57
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/10/57
22c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.,
22d. LOCATION (City, town, or county) (State): Montgomery County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons
ADDRESS: 1756 Pa. Ave., N.W.
24a. REC'D BY REGISTRAR DATE: 6-11-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6556 **CERTIFICATE OF DEATH** 06535 Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3812 Woodbine St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Chevy Chase
d. STREET ADDRESS: 1 3812 Woodbine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Spencer Last Nesbitt
4. DATE OF DEATH: Month June Day 25, Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 27, 1905
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months 5 Days 28 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Army Officer-Retired.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: William F. Nesbitt
14. MOTHER'S MAIDEN NAME: Florence S. Spencer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Alice M. Nesbitt Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 15 MINS

DUE TO (b) CORONARY THROMBOSIS & INFARCTION — 2 DAYS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) CHRONIC HYPERTENSION — 8 YRS.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 44X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-17, 1951, to 6-19, 1957, that I last saw the deceased alive on 6-19, 1957, and that death occurred at 6 55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold Sterling M.D. ADDRESS (Street, city or town, state) DATE SIGNED 6/26/57

PHYSICIAN'S NAME (Type): Harold Sterling 1352 University Lane, Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/28/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE 6-27-57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6454

CERTIFICATE OF DEATH

06536
Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY ~~Prince Georges~~ Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring
d. STREET ADDRESS 11016 New HAMPSHIRE Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First FLORENCE Middle Lost NEUMANN
4. DATE OF DEATH Month June Day 11 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 8, 1889
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME MAX Rosebaum
14. MOTHER'S MAIDEN NAME Lena Gundersheim
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Milton Neumann Address 11016 N.H. Ave Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis, left middle cerebral — INTERVAL BETWEEN ONSET AND DEATH: 5 days.
DUE TO
(b) Diabetes mellitus — 30 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X 330X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal insufficiency; Coronary atherosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1957, to June 11, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 7:12 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Norman H. Rubenstein M.D. ADDRESS (Street, city or town, state) 6480 New Hampshire Ave. DATE SIGNED 6/11/57
PHYSICIAN'S NAME (Type) Takoma PARK, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 6/14/57
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill
22d. LOCATION (City, town, or county) (State) Wash., D.C.

23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons ADDRESS 3501-14 St. N.W.
24a. REC'D BY REGISTRAR DATE 6/13/57
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

6455

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Item #2 G-219 8/9/57 GTE

Reg. Dist. No. 06537 7/73

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: 20 months

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 16 X 0

d. STREET ADDRESS: 1372 Kenyon St. N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ANNIE Middle: MADISON Last: Nichols

4. DATE OF DEATH Month: June Day: 1 Year: 1957

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: March 4, 1876

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas A. Miller

14. MOTHER'S MAIDEN NAME: Mary Crockett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Record Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

420.1

DUE TO (b) Posterior Coronary Occlusion (old) — ? years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertension — ? years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 334X

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/23/ 19.55, to June 1 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Hare M.D. ADDRESS (Street, city or town, state): Takoma Park Md. DATE SIGNED: 6/3/57

PHYSICIAN'S NAME (Type): Robert A. Hare

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL **22b. DATE THEREOF:** 6-6-57 **22c. NAME OF CEMETERY OR CREMATORY:** GLENWOOD **22d. LOCATION** (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers. ADDRESS: G. Wash. D.C.

24a. REC'D BY REGISTRAR DATE: JUN 5 1957 **24b. REGISTRAR'S SIGNATURE:** J. Wilson Deb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06538

6557

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church
d. STREET ADDRESS: 622 Whispering Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert; Middle (none); Last Nirenberg
4. DATE OF DEATH: Month June; Day 25; Year 19 57
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 6, 1910
9. AGE (In years last birthday): 47 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Program Analyst
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Louis Nirenberg
14. MOTHER'S MAIDEN NAME: Sara Geldbart
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 530-07-9706
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) probable cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b) rheumatic heart disease & mitral stenosis — 5+ years
DUE TO
(c) unknown causes — —

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 5, 19 57, to June 25, 19 57, that I last saw the deceased alive on June 25, 19 57, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emery C. Herman Jr. M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/25/57
PHYSICIAN'S NAME (Type): Emery C. Herman, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: June 29 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Perry Chase Funeral Home
ADDRESS: West D.C.
24a. REC'D BY REGISTRAR: DATE JUN 27 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6558

CERTIFICATE OF DEATH

06539

Reg. Dist. No. 217

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 17 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co. General Hospital, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: Rt. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Louise — Last: O'Connell

4. DATE OF DEATH: Month: June — Day: 25 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov. Employee

10b. KIND OF BUSINESS OR INDUSTRY: U.S.A.

11. BIRTHPLACE (State or foreign country): Washington D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jeffrey O'Connell

14. MOTHER'S MAIDEN NAME: Eleanor Costello

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 17 hr
DUE TO
(b) Chronic myocarditis — 5 yr
DUE TO
(c) Chronic arthritis — 10 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

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19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to June, 1957, that I last saw the deceased alive on June 24, 1957, and that death occurred at 7:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. — ADDRESS (Street, city or town, state): Sandy Spring Md. — DATE SIGNED: 6/25/57

PHYSICIAN'S NAME (Type): A. D. BONIFANT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 28, 57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md

24a. REC'D BY REGISTRAR DATE 6/28/57

24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6559

CERTIFICATE OF DEATH

06540

Reg. Dist. No. 214

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90

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47x-3

d. STREET ADDRESS: 3107 Cathedral Ave. N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sarah Middle: Elizabeth Last: Peck

4. DATE OF DEATH Month: June Day: 23 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1/16/66

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Rea Pattison

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Allen Peck Address: 3107 Cathedral Ave. N.W.

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDITIS — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO (b) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) CHRONIC MYOCARDITIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

431x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 28, 1957, to 6-23, 1957, that I last saw the deceased alive on JUNE 23, 1957, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry M. Lewden M.D. ADDRESS (Street, city or town, state): 5206 Norway St. DATE SIGNED: 6/23/57

PHYSICIAN'S NAME (Type): Henry M Lewden Chevy Chase, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 6/25/57

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901 14th St. N.W. Washington, D.C.

24a. REC'D BY REGISTRAR DATE: JUN 25 1957

24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6560 **CERTIFICATE OF DEATH** 06541

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: New Jersey b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belmar 67X-3
d. STREET ADDRESS: 608 F Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paula Middle: Jean Marie Last: Pezzella
4. DATE OF DEATH: Month: June Day: 14, Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 16, 1957
9. AGE (In years lost birthday) yrs.: IF UNDER 1 YEAR Months: 3 Days: 29 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Infant)
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Pezzella
14. MOTHER'S MAIDEN NAME: Faith Romano

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. — INTERVAL BETWEEN ONSET AND DEATH: 0

7543

DUE TO (b) Post op. Pulmonary Artery Constriction — 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Congenital Heart disease Ventricular Septal Defect 4 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 4, 1957 to June 14, 1957, that I last saw the deceased alive on June 14, 1957, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence S. Weldon M.D.
ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Maryland
DATE SIGNED: 6/14/57

PHYSICIAN'S NAME (Type): Clarence S. Weldon, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/17/57
22c. NAME OF CEMETERY OR CREMATORY: St. Catherines
22d. LOCATION (City, town, or county) (State): Monmouth County-New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-17-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

9VVVVVVXVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06542

6561 **CERTIFICATE OF DEATH**

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rockville (Rural)
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard Middle: Martin Last: PHELPS
4. DATE OF DEATH: Month: June Day: 29 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2, 1887
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Commercial
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Andrew PHELPS
14. MOTHER'S MAIDEN NAME: Annie MARTIN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 578-12-8048
17. INFORMANT: (Wife) MRS. Estella PHELPS Address: (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1
DUE TO
(b)
DUE TO
(c) Arteriosclerotic cardiovascular disease — Years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 June, 1957, to 29 June, 1957, that I last saw the deceased alive on ~~28~~ 29 June (R.M.), 1957, and that death occurred at 12:48 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Russell Miller Jr. M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 6-29-57

PHYSICIAN'S NAME (Type): RUSSELL MILLER, Jr., LT, MC, USN / U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1 July 1957
22c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery
22d. LOCATION (City, town, or county) (State): Bealsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey ADDRESS: R.A. Pumphrey, 7557 Wisc. Ave., Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-29-57
24b. REGISTRAR'S SIGNATURE: Mary B. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6456

06543 223
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San and Hosp.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphia
d. STREET ADDRESS: 3100 Bucklodge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

16 x 22

3. NAME OF DECEASED (Type or print): First John Middle Adolph Last Plack
4. DATE OF DEATH: Month 6/13/57 Day Year 19
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/18/37
9. AGE (In years last birthday): 19 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): nursery work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Adolph H. Plack
14. MOTHER'S MAIDEN NAME: Helen G. Boeck
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Helen Plack Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive peritoneal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
(b) Rupture of the liver
DUE TO
(c) Trauma to the abdomen

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.

9028

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Dived about 30 ft and struck head on submerged rock
20c. TIME OF INJURY: Hour 5:45 a.m. p.m. Month, Day, Year 6/13/57 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): creek
20f. (City or town) Silver Spring (County) Montg (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/13/57
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 15, 1957
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
22d. LOCATION (City, town, or county) Prince George County (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St NW D.C.
24a. REC'D BY REGISTRAR DATE 6/15/57
24b. REGISTRAR'S SIGNATURE: J. Milton Dodd

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6562 Items 13,14 Film G217 7-5-57 et. Reg. Dist. No. 065442/3

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Off Md-R 355 1½ mi. W.Clarksburg

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manor 75 x .3
d. STREET ADDRESS: Valley St., Box 157
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry Middle Andy Last Podgurski
4. DATE OF DEATH: Month 6 Day 22 Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/4/20
9. AGE (In years last birthday): 37 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pilot, Commercial
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andy Podgurski
14. MOTHER'S MAIDEN NAME: Frances Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 175-14-4480
17. INFORMANT: Capital Airline Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries, Extreme — INTERVAL BETWEEN ONSET AND DEATH: sudden

86 MX

DUE TO (b) Body & Extremities badly Mutilated

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Accident
20c. TIME OF INJURY Hour 9:00 a.m. p.m. Month, Day, Year 6/22/57 19
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): country
20f. (City or town) Clarksburg (County) Montg. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 6/22/57

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-26-57
22c. NAME OF CEMETERY OR CREMATORY: St Bonifac
22d. LOCATION (City, town, or county): Penn. (State) Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Miller Funeral Home. ADDRESS: Manor. Pa,
24a. REC'D BY REGISTRAR DATE JUN 25 1957
24b. REGISTRAR'S SIGNATURE: Lowell Kraytzer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6461 **CERTIFICATE OF DEATH** 06545

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville-
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville
d. STREET ADDRESS 151 South Adams St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARTHA Middle ANNA Last POTTS
4. DATE OF DEATH Month June Day 17, Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JULY 31, 1872
9. AGE (In years lost birthday) 84 yrs. IF UNDER 1 YEAR: Months 10 Days 16 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jessie N. Potts
14. MOTHER'S MAIDEN NAME Anna Cowman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Martha Burdette- Item #2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 16 June 57
DUE TO (b) Geriatrosclerosis — 20 yrs
DUE TO (c)

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
450.0 Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19 46, to 17 June, 19 57, that I last saw the deceased alive on 17 June, 1957, and that death occurred at 8:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE W. S. Murphy M.D. ADDRESS (Street, city or town, state) Rockville Maryland DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6/20/57
22c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery
22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE JUN 21 '57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6563

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06546 2 4

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 12019 Georgia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDWARD; Middle: WOODROW; Last: PRATT
4. DATE OF DEATH: Month: June; Day: 9; Year: 1957
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: February 24, 1913
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Landscaper
10b. KIND OF BUSINESS OR INDUSTRY: Landscaping
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Thomas Pratt
14. MOTHER'S MAIDEN NAME: Mary Louise Turner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 578-10-0512
17. INFORMANT: Charles A. Pratt — Address: 12019 Georgia Avenue, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage of the pons — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
331X
DUE TO (b): Hypertention
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
444X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) cause of death
Reported to have been in fight which had nothing to do with/
20c. TIME OF INJURY: Hour 1200 o. m.; Month, Day, Year: 6 - 9 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) Silver Spring (County) Montgomery (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart, M. D.
DATE SIGNED: 10 June 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 12, 1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county): Arlington (State): Va.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters by Hm Day
ADDRESS: 254 Carroll St. NW D.C.
24a. REC'D BY REGISTRAR: DATE: JUN 11 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6564

CERTIFICATE OF DEATH

06547
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wood Acres
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5600 Harwick Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Wood Acres
d. STREET ADDRESS: 5600 Harwick Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Katherine Middle Sharpe Last Putnam

4. DATE OF DEATH: Month June Day 2 Year 1957

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/14/1900
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greensboro, N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jules Sharpe
14. MOTHER'S MAIDEN NAME: Elizabeth Donnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Clarence I. Sanders — Address: unknown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Pulmonary Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 MO
DUE TO
(b) Breast Carcinoma — 34 RS.
DUE TO
(c)
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cervical & Lumbar Spine Metastasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 3, 1957, to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 2:20 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D. J. Brennan M.D.
ADDRESS (Street, city or town, state): 463 Montgomery Ave. Bethesda, Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6/4/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince George County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR DATE: JUN 5 1957
24b. REGISTRAR'S SIGNATURE: M. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6565 **CERTIFICATE OF DEATH** 06548

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 45 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3

d. STREET ADDRESS: 3827 Kansas Avenue, N. W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Della Middle Queen Last Rattley

4. DATE OF DEATH: Month June Day 22, Year 19 57

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1907

9. AGE (In years last birthday): 50 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Tall Foster

14. MOTHER'S MAIDEN NAME: Mattie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

200.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c) Malignant Lymphosarcoma - Mycosis Fungoides 4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

519.2 Bilateral Pleural Effusions

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 8, 19 57, to June 22, 19 57, that I last saw the deceased alive on June 22 19 57, and that death occurred at 11:22 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur J. Garceau M.D. ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED: 6/23/57

PHYSICIAN'S NAME (Type): ARTHUR J. GARCEAU, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 6-26-57 22c. NAME OF CEMETERY OR CREMATORY: Carnes Mem. 22d. LOCATION (City, town, or county) (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. Ernest Harris ADDRESS: 1432 Gen. W. DATE: JUN 25 1957 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE: Beskie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6566

CERTIFICATE OF DEATH

06549

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9513 Milstead Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances Middle: Sensabaugh Last: REAL

4. DATE OF DEATH: Month: June Day: 3 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 11, 1934
9. AGE (In years last birthday): 23 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Leon SENSABAUGH
14. MOTHER'S MAIDEN NAME: Mary GREER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Jack O. REAL (Husband) Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Staphylococcal pneumonia - Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b) BRONCHIAL ASTHMA — 16 years.
DUE TO (c)

241X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): FULL TERM 39 WK PREGNANCY DELIVERED 5/28/57

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 27, 1957, to June 3, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 1055 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold I. Passes M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 6-3-57

PHYSICIAN'S NAME (Type): Harold I. Passes, LT,MC,USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-8-57
22c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
22d. LOCATION (City, town, or county) (State): Birmingham, Alabama

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, MD
24a. REC'D BY REGISTRAR DATE: 6-3-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6567

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06550 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Mon tgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Swains Lock
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac River

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Virginia b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church 83X-3
d. STREET ADDRESS: 6402 Powell St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Richard Last Rice
4. DATE OF DEATH: Month 6/17/57 Day Year 19
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/7/42
9. AGE (In years last birthday): 14 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James R. Rice
14. MOTHER'S MAIDEN NAME: Margaret C. Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother Address: Same as Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
929.8
DUE TO (b) Drowning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in Potomac River
20c. TIME OF INJURY Hour 5:30 ~~a.m.~~ p.m. Month, Day, Year 6/17/57 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River
20f. (City or town) (County) (State) Swains Lock Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 21, 1957
22c. NAME OF CEMETERY OR CREMATORY: Nat'l. Mem. Park
22d. LOCATION (City, town, or county) (State): Falls Church, Va.
23. FUNERAL DIRECTOR'S SIGNATURE: J. M. Crickenberger ADDRESS: Vienna, Va.
24a. REC'D BY REGISTRAR DATE: JUN 24 1957
24b. REGISTRAR'S SIGNATURE: Laurell Hughes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6568

CERTIFICATE OF DEATH

Reg. Dist. No. 06551 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 13½ Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 14600 Colesville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Victoria — Last: Richardson

4. DATE OF DEATH: Month: June — Day: 15 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/14/69
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Jacob V. Van Horn
14. MOTHER'S MAIDEN NAME: Sarah E. Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lula Edwards — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
241X
DUE TO (b) Bronchial Asthma — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 422.2

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/1/ 19 57, to 6/15/ 19 57, that I last saw the deceased alive on 6/15/ 19 57, and that death occurred at 2:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. W. Bird — M.D. — ADDRESS (Street, city or town, state): Sandy Spring — DATE SIGNED: 6/15/57

PHYSICIAN'S NAME (Type): J. W. Bird, M. D. — Sandy Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/18/57
22c. NAME OF CEMETERY OR CREMATORY: COLESVILLE CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE 6/17/57
24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6569

CERTIFICATE OF DEATH

Reg. Dist. No. 06552 214

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
c. LENGTH OF STAY IN 1b: 1 Week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Le Deau Gardens rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1615.2
d. STREET ADDRESS: 2721 Nicholson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lena Middle Last Richter
4. DATE OF DEATH: Month June Day 23, Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 1, 1882
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unk. Schenck
14. MOTHER'S MAIDEN NAME: Dora Unk.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Dorothea Damm Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

600.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

434.3

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 27, 1956, to June 23, 1957, that I last saw the deceased alive on June 22, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ronald S. Fleischer M.D. ADDRESS (Street, city or town, state): 5432 Queens Chapel Rd DATE SIGNED: 6/24/57

PHYSICIAN'S NAME (Type): RONALD S. FLEISCHER Hyattsville Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 26, 1957
22c. NAME OF CEMETERY OR CREMATORY: George Washington
22d. LOCATION (City, town, or county) (State): Hyattsville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: JUN 28 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6570

CERTIFICATE OF DEATH

06553

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg 13X12
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First George; Middle Washington; Last Ridgely

4. DATE OF DEATH: Month June; Day 22; Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 6/23/89 6-23-1889

9. AGE (In years last birthday) 68 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Ridgely

14. MOTHER'S MAIDEN NAME Ruth Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT Hospital Record Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH 8 hours

491X

DUE TO (b) toxic myocarditis — 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Bronchopneumonia — 2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

431X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 21, 1957, to June 22, 1957, that I last saw the deceased alive on June 22, 1957, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Charles S. Whitaker, M.D. ADDRESS (Street, city or town, state) DATE SIGNED 6/22/5

PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D. Clarksville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) burial

22b. DATE THEREOF 6/25/57

22c. NAME OF CEMETERY OR CREMATORY Mt. View

22d. LOCATION (City, town, or county) (State) Alpha, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbothom ADDRESS Ellicott City, Md.

24a. REC'D BY REGISTRAR DATE JUN 25 1957

24b. REGISTRAR'S SIGNATURE Gertrude Lawlor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6571

CERTIFICATE OF DEATH

06554

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 16. 15X-1
d. STREET ADDRESS: 5119 NEWPORT AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: ROMULUS Middle: Last: RODMAN

4. DATE OF DEATH: Month: JUNE Day: 12 Year: 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 3-12-1873
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PEARSON RODMAN
14. MOTHER'S MAIDEN NAME: CATHERINE (NOT KNOWN)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RUSSELL RODMAN - SON Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Pulmonary Infarction and — INTERVAL BETWEEN ONSET AND DEATH
163X
DUE TO
(b) extensive Bronchopneumonia
DUE TO
(c) primary Carcinoma of lung.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
465X

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1952 to June 12, 1957, that I last saw the deceased alive on June 12, 1957, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: DeWitt E. DeLawter M.D.
ADDRESS (Street, city or town, state): 8025 ABERDEEN RD Bethesda 14, MARYLAND
DATE SIGNED: 6/12/57
PHYSICIAN'S NAME (Type): DeWITT E. DeLAWTER, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/15/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cem.
22d. LOCATION (City, town, or county) (State): Bladensburg R.d. Washington D C

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE 6-14-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06555

6572 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery COUNTY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4913 Bayard Boulevard

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
STREET ADDRESS (If rural give location): 4913 Bayard Boulevard

3. NAME OF DECEASED: (Type or Print) (First) Harriet (Middle) L. (Last) Runbeck

4. DATE OF DEATH: (Month) June (Day) 19 (Year) 1957

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 2/9/1883
9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months 4 Days 10 IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown Farish

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Merl Sliter--address unknown

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

570.4

IMMEDIATE CAUSE (A) Pneumonia — 36 hrs.

DUE TO

ANTECEDENT CAUSE (S) (B) ileostomy 2° intestinal obstruction (postoperative) — 5 wks.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: intestinal obstruction due to gall stone.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 1957, to 19 June, 1957, that I last saw the deceased alive on 18 June, 1957, and that death occurred at 6:10 P M, from the causes and on the date stated above.

SIGNATURE John M. Hymson M.D. ADDRESS 7657 Georgetown Rd. Bethesda 14, Md. DATE SIGNED 19 June 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 6/22/57
NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
LOCATION (City, town, or county) (State): Suitland, Maryland

DATE REC'D BY LOCAL REGISTRAR: 6-24-57
REGISTRAR'S SIGNATURE: Bernie M. Thompson
24. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6573

CERTIFICATE OF DEATH

06556

Reg. Dist. No. 02 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1425 Congress Place, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie; Middle: (nmn); Last: RUSH

4. DATE OF DEATH: Month: June; Day: 10; Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 9, 1957

9. AGE (In years last birthday) yrs.; IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: 11; Min.: 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Willie Lee RUSH

14. MOTHER'S MAIDEN NAME: Juanita L. DEAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Father, Willie Lee RUSH (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREMATURITY 26-28 WEEKS — INTERVAL BETWEEN ONSET AND DEATH: 8 HOURS
776X
DUE TO
(b) GESTATION.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 9, 1957, to June 10, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 2:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel Shuptar M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-11-57

PHYSICIAN'S NAME (Type): Daniel SHUPTAR, LT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 6-12-57

22c. NAME OF CEMETERY OR CREMATORY: U.S. Naval Medical School

22d. LOCATION (City, town, or county) (State): Bethesda 14, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Naval Medical School, NNMC, Bethesda, Maryland

24a. REC'D BY REGISTRAR — DATE: 6-12-57

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

205/192XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6457

CERTIFICATE OF DEATH

06557

Reg. Dist. No. 773

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San & Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 15303 Glenwood Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Lucy; Middle Effie; Last Rusk
4. DATE OF DEATH: Month June; Day 22; Year 1957

5. SEX: Fe
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 6/10/72
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ill
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hammerbocker
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral thrombosis	2 wks
332x DUE TO (b)	Cerebral atherosclerosis + old thrombosis	3 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Hypertension	7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 446x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 24, 1957 to June 22, 1957 That I last saw the deceased alive on 6/21, 1957, and that death occurred at 7:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H Wolohan M.D.
ADDRESS (Street, city or town, state): 5 Underwood St NW Wash. DC
DATE SIGNED: 6/22/57
PHYSICIAN'S NAME (Type): Chas H WoLoHoN

22a. BURIAL, CREMATION, ~~REMOVAL (Specify)~~
22b. DATE THEREOF: 6/25/57
22c. NAME OF CEMETERY OR CREMATORY: Wash. Nat. Cemetery
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,
ADDRESS: 2901 14th St.N.W. Wash,D.C.
24a. REC'D BY REGISTRAR DATE: JUN 24 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6574

CERTIFICATE OF DEATH

06558

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 2209 40th Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Joseph — Last: RYAN
4. DATE OF DEATH: Month: June — Day: 20 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 3, 1904
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Marine Corps
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Bernard RYAN
14. MOTHER'S MAIDEN NAME: Leelinau LUTON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: (Sister) Mrs. Leelinau MC DONALD — Address: (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Esophageal Varices — Interval between onset and death: Unknown
581.0
DUE TO (b) Cirrhosis of Liver — Interval: unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 3, 1957, to June 20, 1957, that I last saw the deceased alive on June 20, 1957, and that death occurred at 9:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE x Henry B Karpinski M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-20-57

PHYSICIAN'S NAME (Type): Henry B. KARPINSKI, LT MC USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-24-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: S.H. Hines — ADDRESS: 2901 14th St., N.W. Washington, D.C.
24a. REC'D BY REGISTRAR: DATE 6-20-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06559

6575

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47x-3
d. STREET ADDRESS: 2319 King Place N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First NELLIE Middle J Last SAUNDERS
4. DATE OF DEATH: Month JUNE Day 25 Year 1957
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT 9, 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: DEXTER DRAKE
14. MOTHER'S MAIDEN NAME: JULLIETT SANDERSONS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: DR. C.K. SAUNDERS Address: 2319 KING PLACE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS
420.0
DUE TO
(b) Arteriosclerotic HEART DISEASE — 2 YRS
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
434.1
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE, 1955, to JUNE 25, 1957, that I last saw the deceased alive on JUNE 22, 1957, and that death occurred at 4 a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William T. Saccardi M.D. — ADDRESS (Street, city or town, state): 123 — DATE SIGNED: 6/25/57
PHYSICIAN'S NAME (Type): WILLIAM T SACCARDI

22a. BURIAL, CREMATION, REMOVAL (Specify): removal
22b. DATE THEREOF: 6/25/57
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Cleveland, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company, ADDRESS: 2901 14th St. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR DATE: JUN 27 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6576 Item 2 FilmG217 7-11-57 et

CERTIFICATE OF DEATH

06560 Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alta Vista Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47x-3
d. STREET ADDRESS: 1115-12th St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Last: Sherlock
4. DATE OF DEATH: Month: June Day: 24 Year: 1957
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1869
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Sherlock
14. MOTHER'S MAIDEN NAME: Belle Seymour
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Miss Mildred Page Address: 926 Mass. Ave. N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 + years
450.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Summer, 1954, to June 24, 1957 that I last saw the deceased alive on June 23, 1957, and that death occurred at 6:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Alban W. Eger M.D. ADDRESS (Street, city or town, state): Washington 6, D.C. DATE SIGNED:
PHYSICIAN'S NAME (Type): Alban W. Eger 1801 Eye Street, N.W.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: June 26-1957
22c. NAME OF CEMETERY OR CREMATORY: J. Wm Lee's Sons Co.
22d. LOCATION (City, town, or county) (State): Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: J. Wm Lee's Sons Co. ADDRESS: 300-4th St. N.E.
24a. REC'D BY REGISTRAR DATE: 6-27-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6577 **CERTIFICATE OF DEATH** 06561

Reg. Dist. No. 213

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9800 Great Falls Road
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rural- Rockville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Rockville x2
d. STREET ADDRESS: 9800 Great Falls Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie Middle: Elizabeth Last: SHORB

4. DATE OF DEATH: Month: June Day: 21, Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 8, 1871

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months: 0 Days: 13 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hamilton R. Geisbert

14. MOTHER'S MAIDEN NAME: Martha R. Ramsburg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Glenn W. Shorb-Same Item #2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
154X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) adenocarcinoma of uterus — 1 yr
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1, 1956 to 6/21/1957, that I last saw the deceased alive on 6/21/1957, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones M.D. ADDRESS (Street, city or town, state): Rockville Md DATE SIGNED: 6/22/57

PHYSICIAN'S NAME (Type): Stephen N. Jones, M. D. Rockville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/24/1957

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Frederick Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-7557 Wisconsin Avenue Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 24 1957

24b. REGISTRAR'S SIGNATURE: Laurella Lingtorp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06562

6462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 718 E. Montgomery Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 1 718 E. Montgomery Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) xxx — First: Ella — Middle: — Last: Simmons

4. DATE OF DEATH — Month: June — Day: 30 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 19, 1873
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: 8 Days: 11
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Bennett Cooper
14. MOTHER'S MAIDEN NAME: Nancy Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dennis C Simmons-Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 min
420.1
DUE TO
(b): Myocardial Infarction — 1 hr
DUE TO
(c): Arteriosclerotic C-V Disease — Indefinite
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Gall-bladder disease
586x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 12, 1956, to June 30, 1957, that I last saw the deceased alive on June 30, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones M.D. — ADDRESS (Street, city or town, state): Rockville Md — DATE SIGNED: 6/30/57

PHYSICIAN'S NAME (Type): Stephen N. Jones-Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/2/57
22c. NAME OF CEMETERY OR CREMATORY: Walker Farm Cemetery
22d. LOCATION (City, town, or county) (State): Tyrrell County, N. Carolina

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: 7/2/57
24b. REGISTRAR'S SIGNATURE: Laurell Kraytop Pr. E.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6578 **CERTIFICATE OF DEATH** Reg. Dist. No. 06563 276

M

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 170 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: West Virginia b. COUNTY: Grant
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gormania 85 X - 3
d. STREET ADDRESS: Route 1, Box 98
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

50

3. NAME OF DECEASED (Type or print): First Guy; Middle Dailey; Last Simmons
4. DATE OF DEATH: Month June; Day 15; Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 9, 1902
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Automobile
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Samuel Simmons
14. MOTHER'S MAIDEN NAME: Cora Pifer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-10-7991
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of floor of mouth, metastatic
143X
~~DUE TO~~
(b) Jugular vein compression
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Septicemia
19. WAS AUTOPSY PEREORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 27, 1956, to June 15, 1957, that I last saw the deceased alive on June 15, 1957, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter D. Olch M.D. M.D. ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED: 6/16/57

PHYSICIAN'S NAME (Type): Peter D. Olch, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/18/57
22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
22d. LOCATION (City, town, or county) (State): Oakland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Lloyd F. Brickhouse Sons ADDRESS: 3034 M St., N.W. Wash., D.C.
24a. REC'D BY REGISTRAR DATE 6-18-57
24b. REGISTRAR'S SIGNATURE: Beatrice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6579 **CERTIFICATE OF DEATH** 06564

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Beall Mountain, Rockville, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rural, Rockville
d. STREET ADDRESS: Beall Mountain
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lyndon Middle: F Last: Small

4. DATE OF DEATH: Month: 6 Day: 15 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/16/1897

9. AGE (In years lost birthday): 59 yrs. IF UNDER 1 YEAR: Months 9 Days 29 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHD-Scientist

10b. KIND OF BUSINESS OR INDUSTRY: Research

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick E. Samll

14. MOTHER'S MAIDEN NAME: Amanda Cary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. M. C. Small Address: item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition — INTERVAL BETWEEN ONSET AND DEATH: Dec 26, 1956
151X
DUE TO
(b) Carcinoma of esophagus with — & June 16, 1957
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) metastases to pleural cavity.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1957, to death, 19____, that I last saw the deceased alive on 6/13, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lyndon E. Lee Jr. M.D. ADDRESS (Street, city or town, state): U.S. Veterans Admin - Washington 25, DC. DATE SIGNED

PHYSICIAN'S NAME (Type): Lyndon E. Lee Jr. MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 6/17/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE 6/19/57

24b. REGISTRAR'S SIGNATURE: Laurell Kraftowp for E.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6580

CERTIFICATE OF DEATH

06565

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 16 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oak Lawn Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Washington — b. COUNTY: D.C. (Nort)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 517 Albany St. N.W.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helen — Middle L — Last Smith
4. DATE OF DEATH: Month 6 — Day 25 — Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 25, 1888
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Syracuse N.Y. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Market
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: John C Smith — Address: Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
332X
DUE TO (b): Hypertension + gen. arteriosclerosis — 7 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
447X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1957 to June 25, 1957 that I last saw the deceased alive on 6/25, 1957, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: D B Washington M.D. — ADDRESS (Street, city or town, state): 6234 Georgia Ave N.W. Wash DC — DATE SIGNED: 6/27/57
PHYSICIAN'S NAME (Type): D.B. Washington MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial.
22b. DATE THEREOF: 6/29/57
22c. NAME OF CEMETERY OR CREMATORY: Assumption Cemetery.
22d. LOCATION (City, town, or county) (State): Syracuse N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: W K Hunteman & Son — ADDRESS: 5732 Ga Ave N.W.
24a. REC'D BY REGISTRAR DATE: 6/28/57
24b. REGISTRAR'S SIGNATURE: J Milton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6581

06566

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 10905 DRUMM AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: PAMELA Middle: LEE Last: SORRELL

4. DATE OF DEATH: Month: JUNE Day: 8 Year: 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-2-1957
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: Days: 6
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED SORRELL
14. MOTHER'S MAIDEN NAME: GRACE WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: FRED SORRELL Address: 10905 DRUMM AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Bilateral Atelectasis — INTERVAL BETWEEN ONSET AND DEATH

762.5

DUE TO (b) Prematurity (6½ months gestation) — 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE 2, 1957, to JUNE 8, 1957, that I last saw the deceased alive on JUNE 8, 1957, and that death occurred at 5:25 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sydney Ross M.D. M.D. ADDRESS (Street, city or town, state): 5415 Conn. Ave. NW. Wash. D.C. DATE SIGNED

PHYSICIAN'S NAME (Type): Sydney Ross M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6/10/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 6-11-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2074335XVO

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6582 **CERTIFICATE OF DEATH** 06567

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4319 Center Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase x2
d. STREET ADDRESS: 4319 Center Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First M. Middle ROSALIE Last SPROW
4. DATE OF DEATH: Month June Day 27 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/6/1903
9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dietician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Leopold, Indiana
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter Solbrig
14. MOTHER'S MAIDEN NAME: Katherine Goffinet
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 308-24-7199
17. INFORMANT: Evelyn Richardson, (Same as # 2) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
581.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cirrhosis of Liver — 2 yrs ?
DUE TO
(c) Hepatitis — 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1955, to 6/27, 1957, that I last saw the deceased alive on 6/26/57, 19____, and that death occurred at 2:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. B. Sims M.D. ADDRESS (Street, city or town, state): 1150 Connecticut ave DATE SIGNED: 6/27/57

PHYSICIAN'S NAME (Type): W. B. SIMS, M.D. Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/29/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Bawlers Sons ADDRESS: 1756 Pa. Ave., N.W. DC
24a. REC'D BY REGISTRAR DATE 6-27-57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6458 **CERTIFICATE OF DEATH** 16568

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San. & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 12416 Denley Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Leo Lost Stapleton

4. DATE OF DEATH: Month June Day 29 Year 1957

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-5-89
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Mr. James Stapleton
14. MOTHER'S MAIDEN NAME: Mary Catherine Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WW # 1
16. SOCIAL SECURITY NO. 214-03-4072-A
17. INFORMANT: Chart Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH
540.0
DUE TO (b) MASSIVE BLEEDING FROM GASTRIC ULCERS — 2 wks.
DUE TO (c) SHOCK - POST - SUBTOTAL GASTRECTOMY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While of work ☐ Not while of work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 27, 1957 to June 29, 1957 that I last saw the deceased alive on June 29, 1957, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frederick B Brandt M.D. ADDRESS (Street, city or town, state): 1726 Eye NW, D.C. DATE SIGNED

PHYSICIAN'S NAME (Type): FREDERICK B. BRANDT M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/3/57
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE 7/2/57
24b. REGISTRAR'S SIGNATURE: J. Milton Dodd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06569

CERTIFICATE OF DEATH

6463

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 10 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Congressional Manor Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3636 - 16th St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA; Middle N.; Last STEINER

4. DATE OF DEATH: Month June; Day 14; Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1890

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months 4; Days 19
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't Retired

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Benjamin Weems

14. MOTHER'S MAIDEN NAME: Mary Rutherford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Robert F. Steiner — Address: 5810 Wilmett Road Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
DUE TO (b) Arteriosclerosis & Thrombosis Coronary
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old Myocardial infarction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1957, to June 13, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Bowditch Hunter Jr. M.D. — ADDRESS (Street, city or town, state): 809 Viers Mill Rd. Rockville, Maryland — DATE SIGNED: 6/14/57

PHYSICIAN'S NAME (Type): G. Bowditch Hunter, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-18-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR — DATE 6/17/57

24b. REGISTRAR'S SIGNATURE: Laurence Kraftorp per E.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6583 **CERTIFICATE OF DEATH** 06570

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10305 Haywood Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 10305 Haywood Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Albert; Middle:; Last: Stern

4. DATE OF DEATH: Month: June; Day: 20; Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 3, 1898
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Mandel Stern
14. MOTHER'S MAIDEN NAME: Mollie Fine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hetty Stern — Address: 10305 Haywood Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ACUTE CORONARY OCCLUSION — 1 hr
DUE TO
(c) ARTERIOSCLEROTIC C.V.D. — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-20, 1957, to 6-20, 1957, that I last saw the deceased alive on 6-20, 1957, and that death occurred at 10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard H. Ostrow M.D. — ADDRESS (Street, city or town, state): 7961 Eastern Ave., Sil. Spg., Md. — DATE SIGNED: 6-20-57

PHYSICIAN'S NAME (Type): Bernard H. Ostrow

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 23, 1957
22c. NAME OF CEMETERY OR CREMATORY: King David Mem. Garden
22d. LOCATION (City, town, or county) (State): Falls Church, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: B. Danzansky & Sons — ADDRESS: Washington, D.C.
24a. REC'D BY REGISTRAR: DATE 6/28/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 B

M

74

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6584

CERTIFICATE OF DEATH

06571

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 1500 East West Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hannah; Middle: S; Last: Stewart

4. DATE OF DEATH: Month: June; Day: 29; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 29, 1894

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Calvin Saltzer

14. MOTHER'S MAIDEN NAME: Emma Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harrison M. Stewart — Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b) Arteriolonephrosclerosis
DUE TO (c)

446 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 572.1 Jejunal diverticulosis with gastrointestinal hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 29 June, 19 57, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L Marshall Cuvillier, M.D. — ADDRESS (Street, city or town, state): 1407 Woodside Parkway, Silver Spring, Maryland — DATE SIGNED:

PHYSICIAN'S NAME (Type): L. Marshall Cuvillier

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-2-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins — ADDRESS: 3821 14th St. N.W. Wash. D.C.

24a. REC'D BY REGISTRAR DATE: 7-3-57

24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6585 **CERTIFICATE OF DEATH** Reg. Dist. No. 06572 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda x2
d. STREET ADDRESS: 5311 Locust Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jesse Middle Cyrus Last Stoddard
4. DATE OF DEATH: Month June Day 27 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 16 1886
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Josiah Stoddard
14. MOTHER'S MAIDEN NAME: Lucy Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: John C. Stoddard — Address: Bethesda 9514 Milstead Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
(b) Arteriosclerotic Heart disease
DUE TO
(c)

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 491x Bilateral confluent bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 June, 1957, to 27 June, 1957, that I last saw the deceased alive on 27 June, 1957, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Horace W. Benton M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/29/57
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 6-30-57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1[redacted]

6536

CERTIFICATE OF DEATH

Reg. Dist. No. 06573 2/2

1. PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA

c. LENGTH OF STAY IN 1b: 2 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ DICKERSON

d. STREET ADDRESS: ROUTE 2

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

74

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: FREDERICK Last: STONE

4. DATE OF DEATH Month: 6 Day: 7 Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/5/76

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter — Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE C. STONE

14. MOTHER'S MAIDEN NAME: ELLEN N. FRALEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-03-6974A

17. INFORMANT: ROBERT O. STONE [redacted] 1445 OGDEN ST. NW. WASHINGTON .D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardio-Vasc. Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1953, to 7 June, 1957, that I last saw the deceased alive on 7 June, 1957, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon N. Smith M.D. ADDRESS (Street, city or town, state): Barnesville, Maryland DATE SIGNED: 8 June 57

PHYSICIAN'S NAME (Type): Gordon N. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial **22b. DATE THEREOF:** 6/11/57 **22c. NAME OF CEMETERY OR CREMATORY:** Mt Zion **22d. LOCATION** (City, town, or county) (State): Fraggville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton ADDRESS: Barnesville Md

24a. REC'D BY REGISTRAR DATE 6/10/57 **24b. REGISTRAR'S SIGNATURE:** Charles W. Elgin per [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6587

CERTIFICATE OF DEATH

06574

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Arlington
d. STREET ADDRESS: 4773 24th Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia — Middle: Hodgson — Last: SUTLIFF

4. DATE OF DEATH: Month: June — Day: 5 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 15, 1908
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank B. HODGSON
14. MOTHER'S MAIDEN NAME: Kathryn POWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: (Husband) Robert C. SUTLIFF (Same As #2) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, Metastatic to Brain — INTERVAL BETWEEN ONSET AND DEATH
170X
DUE TO
(b) Anaplastic Carcinoma, Rt. Breast — 4 mos.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 30, 1957, to June 5, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 3:10A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: T.S. Dunn Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 6-5-57

PHYSICIAN'S NAME (Type): T.S. DUNN, JR., LT,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-7-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. Gawler & Sons — ADDRESS: Gawler's & Sons, 1756 Penn. Ave., N.W. Wash. D.C.
24a. REC'D BY REGISTRAR: DATE 6-5-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06575

6588

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 101 days
d. NAME OF HOSPITAL (If not in hospital, give address) OR INSTITUTION: The Clinical Center National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glencove 62x-3
d. STREET ADDRESS: (No street address)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nettie — Middle Alice — Last Steines
4. DATE OF DEATH: Month June — Day 8, — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 26 April 1893
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mathis Lehmann
14. MOTHER'S MAIDEN NAME: Amelia Huncke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE MYELOMA — INTERVAL BETWEEN ONSET AND DEATH: 8 Mos.
203X
DUE TO (b) ARTERIAL SCLEROSIS, SEVERE, C ASHD — YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) PNEUMONIA, LEFT LOWER LOBE — DAYS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
493X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 27, 1957, to June 8, 1957, that I last saw the deceased alive on June 8, 1957, and that death occurred at 7.00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gurston Goldin M.D.
ADDRESS (Street, city or town, state): The Clinical Center National Institutes of Health Bethesda 14, Md.
DATE SIGNED: 6/9/57
PHYSICIAN'S NAME (Type): Gurston Goldin, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 6-10-57
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-11-57
24b. REGISTRAR'S SIGNATURE: Bernice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6589

CERTIFICATE OF DEATH

06576

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 55 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: The Clinical Center, National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83 X-3
d. STREET ADDRESS: 108 Wythe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Hershelia — Last: Strange

4. DATE OF DEATH: Month: June — Day: 3, — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 16 August 1909

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Lyles

14. MOTHER'S MAIDEN NAME: Harriet Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT (Name, address): The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Cervix uteri c direct extension to all pelvic organs & extensive metastases to all abdominal structures
DUE TO (b)
DUE TO (c)

171 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Right hydronephrosis & small & large bowel obstruction

60 X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 9, 1957, to June 3, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 5.00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chester Z. Haverback M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/5/57

PHYSICIAN'S NAME (Type): Chester Z. Haverback, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): 6/5/57
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: Bethel
22d. LOCATION (City, town, or county) (State): Alexandria Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Arnold Funeral Home 311 N. Patrick St.

24a. REC'D BY REGISTRAR DATE 6/6/57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6590

CERTIFICATE OF DEATH

06577

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Silver Spring
d. STREET ADDRESS: 704 Roeder St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle K Last TAYLOR
4. DATE OF DEATH: Month June Day 15 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 28 1868
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: S. Mason
14. MOTHER'S MAIDEN NAME: Sarah ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charlotte Gable Address 704 Roeder St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arterio Sclerosis — 5 years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-23, 1951, to 6-15, 1957, that I last saw the deceased alive on 6-14, 1957, and that death occurred at 10:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W B Wardrop M.D. ADDRESS (Street, city or town, state): 837 Bonifant St. Silver Spring DATE SIGNED: 6/15/57

PHYSICIAN'S NAME (Type): W. B. WARDROP 837 BONIFANT ST. SILVER SPRING MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-17-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home ADDRESS: 4812 Ga Ave Wash DC
24a. REC'D BY REGISTRAR DATE: JUN 20 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6591

CERTIFICATE OF DEATH

06578 216

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 7 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47x-3
d. STREET ADDRESS: 4017 VANNESS ST. NW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DWIGHT Middle KIGGINS Last TERRY
4. DATE OF DEATH: Month JUNE Day 14 Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 10-1898
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. POST OFFICE
10b. KIND OF BUSINESS OR INDUSTRY: WASH. DC
11. BIRTHPLACE (State or foreign country): U.S.A
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: GEORGE E TERRY
14. MOTHER'S MAIDEN NAME: SARA KIGGINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 1917 -
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS HELEN TERRY (WIFE) Address: 4017 VANNESS WASH 16 DC.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) massive cerebro-pontine hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours
331 X
DUE TO
(b) Hypertension — ? years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral Congenital Polycystic Kidneys
757.1
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.: None
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19____, to present, 19____, that I last saw the deceased alive on 6/14/57, 19____, and that death occurred at 12:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Umhau M.D. ADDRESS (Street, city or town, state): 8805 Conn. Ave DATE SIGNED: 6/14/57
PHYSICIAN'S NAME (Type): JOHN B. UMHAU Chevy Chase Md

22a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~: burial
22b. DATE THEREOF: 6/17/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., ADDRESS: Wash, D.C. 2901 14th St. N.W.
24a. REC'D BY REGISTRAR DATE: JUN 17 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06579

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac river near Great Falls

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 2833-27th St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EUGENE Middle KELBY Last THOMAS

4. DATE OF DEATH: Month June Day 17, Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: July 6, 1927
9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Horace Kelby Thomas
14. MOTHER'S MAIDEN NAME: Ethel Lee Allison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Korean
16. SOCIAL SECURITY NO.:
17. INFORMANT: William R. Thomas — Address: Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia by Drowning — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drown while swimming in Potomac River
20c. TIME OF INJURY Hour 6:00 p. m. Month, Day, Year 6-17-1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Item #1
20f. (City or town): Potomac (County): Mtg. (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: June 23, 1957
EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-25-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6593

06580

Reg. Dist. No. 213

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Virginia — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X-3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac R. at Great Falls

d. STREET ADDRESS: Box 312 - Route 4

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Howard — Last Thomas

4. DATE OF DEATH: Month June — Day 23 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/23/1939

9. AGE (In years last birthday): 18 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman

10b. KIND OF BUSINESS OR INDUSTRY: Telephone

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. H. Thomas

14. MOTHER'S MAIDEN NAME: Manda May

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 223-50-5217

17. INFORMANT: John P. Thomas. — Address: Alexanddia Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden

929.8

DUE TO (b): Drowning

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped from rock while wading in Pot. R.

20c. TIME OF INJURY: Hour 5:10 ~~a.m.~~ p.m. — Month, Day, Year 6/23/57

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Great Falls, Pot. R.

20f. (City or town) Potomac (County) Montg (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/25/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-28-57

22c. NAME OF CEMETERY OR CREMATORY: Family Cemetery.

22d. LOCATION (City, town, or county) (State): Trade Tenn.

23. FUNERAL DIRECTOR'S SIGNATURE: William Demaine & Son. — ADDRESS: Alexandria Va.

24a. REC'D BY REGISTRAR: DATE JUN 28 19

24b. REGISTRAR'S SIGNATURE: H. G. Kauer
Lanell Kraytop

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

6594

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 12,13,14 FilmG217 7-11-57 et

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Ill. b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg

c. LENGTH OF STAY IN 1b: DOA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berwyn 51X.3

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Off Md.R-355 1½mi.W. Clarksburg

d. STREET ADDRESS: 6637 W. 21st.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Kenneth Last: Thomas

4. DATE OF DEATH Month: 6 Day: 22 Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5/26/27

9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Co-Pilot

10b. KIND OF BUSINESS OR INDUSTRY: Air Lines

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Thomas

14. MOTHER'S MAIDEN NAME: Florence Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 354-16-6432

17. INFORMANT: Capital Airline Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple Injuries, Extreme — INTERVAL BETWEEN ONSET AND DEATH: sudden

861X

DUE TO (b): Body & Extremities badly Mutilated

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane Accident

20c. TIME OF INJURY Hour: 9:00 a.m. p.m. Month, Day, Year: 6/22/57

20d. INJURY OCCURRED While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): country

20f. (City or town) Clarksburg (County) Montg. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/22/57

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-26-57

22c. NAME OF CEMETERY OR CREMATORY: Milwaukee

22d. LOCATION (City, town, or county): Milwaukee (State) Wisco

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ernest C. Gartner, Gaithersburg. Md.

24a. REC'D BY REGISTRAR DATE: JUN 25 195

24b. REGISTRAR'S SIGNATURE: Lurell Tragley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6595

06582

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10410 Fawcett Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Kensington
d. STREET ADDRESS: 1 10410 Fawcett Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle N. Last TRADER

4. DATE OF DEATH: Month June Day 24 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27 1893

9. AGE (In years lost birthday): 63 yrs. IF UNDER 1 YEAR: Months 8 Days 27 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob P. Norlin

14. MOTHER'S MAIDEN NAME: Jeanette Frost

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary F. Dyott- Easton, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Metastatic Carcinoma
DUE TO
(c) Papillary Carcinoma Left Ovary — 7 yrs

175X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19____, to June 24, 1957, that I last saw the deceased alive on June 23, 1957, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Marion Bankhead M.D. — ADDRESS (Street, city or town, state): 9241 Col. Blvd. — DATE SIGNED: 6/24/57

PHYSICIAN'S NAME (Type): J. Marion Bankhead Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 6/26/57

22c. NAME OF CEMETERY OR CREMATORY: Crown Hill

22d. LOCATION (City, town, or county) (State): Sedalia, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE 6-27-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6596

06583

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Kensington
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4829 Flanders Ave(Garrett Park)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Kensington
d. STREET ADDRESS 4829 Flanders Ave.(Garrett Park)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle PERRY Last TRAIL
4. DATE OF DEATH Month June Day 18 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov.13,1906
9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR: Months 7 Days 5
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher
10b. KIND OF BUSINESS OR INDUSTRY Public Schools
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Wm. P. Trail
14. MOTHER'S MAIDEN NAME Alethia E. Poole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs Mary N. Trail-Item# 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: ONE HOUR
420.1
DUE TO (b) ARTERIAL HYPERTENSION — 15 YEARS
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS — 10 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
447x CONGESTIVE HEART FAILURE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN-10, 1957, to JUNE 18, 1957, that I last saw the deceased alive on JUNE 18 1957, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Gordon S Rosenberger M.D. ADDRESS (Street, city or town, state) 26 N. SUMMIT AVE GAITHERSBURG, MD. DATE SIGNED 19 JUN 1957

PHYSICIAN'S NAME (Type) Gordon S. Rosenberger- Gaithersburg, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6/22/57
22c. NAME OF CEMETERY OR CREMATORY Rockville Union
22d. LOCATION (City, town, or county) (State) Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-24-57
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6597 **CERTIFICATE OF DEATH**

06584

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 61 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8[illegible] New Hampshire Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence; Middle: Virginia; Last: Utermoehlen
4. DATE OF DEATH: Month: June; Day: 1; Year: 19 57
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 24, 1910
9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Variety Store
11. BIRTHPLACE (State or foreign country): ~~Maryland~~ WILLIAMS, W.VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Daniel G. Mumma
14. MOTHER'S MAIDEN NAME: Theresa Zimmerley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-05-2554
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma left pleura - with
DUE TO massive pleural effusion & atelectasis - left lung.
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bowel obstruction - 2° to adhesions
DUE TO around ileum.
(c) ~~[illegible]~~

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ileo cutaneous fecal fistulae - to Rt lower Quadrant + vagina
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1957, to June 1, 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chester Z. Haverback M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 6-2-57

PHYSICIAN'S NAME (Type): CHESTER Z. HAVERBACK, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 5, 1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince Geo. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR: DATE 6-5-57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06585

CERTIFICATE OF DEATH

6598

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 98 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, National Institutes of Health, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1656 West Virginia Ave., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes; Middle: Catherine; Last: Vanne
4. DATE OF DEATH: Month: June; Day: 21; Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 26, 1909
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10b. KIND OF BUSINESS OR INDUSTRY: Unascertainable
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Schlosser
14. MOTHER'S MAIDEN NAME: Catherine Loehman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of cervix — INTERVAL BETWEEN ONSET AND DEATH
171X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 15, 1957, to June 21, 1957, that I last saw the deceased alive on June 21, 1957, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: S Weissman M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 6/21/57
PHYSICIAN'S NAME (Type): Sherman M. Weissman, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: 24 June 57
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cem
22d. LOCATION (City, town, or county) (State): Wash. DC

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 4th + Mass ave NE Wash DC
24a. REC'D BY REGISTRAR DATE 6-25-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6599

CERTIFICATE OF DEATH

06586

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SURBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE X 2
d. STREET ADDRESS: 4713 DRUMMOND AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

74

3. NAME OF DECEASED (Type or print): First JOHN Middle CURTIS Last WALKER
4. DATE OF DEATH: Month JUNE Day 16 Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR-6-1897
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months 3 Days 10 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): APPRAISER
10b. KIND OF BUSINESS OR INDUSTRY: REAL ESTATE
11. BIRTHPLACE (State or foreign country): WASH. DC.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN C. WALKER
14. MOTHER'S MAIDEN NAME: JENNIE YOUNG
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 1917 –
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: CLAXTON WALKER-SON Address

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Coma and Insufficiency
581.0
DUE TO (b) Portal cirrhosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
446x Arteriolar Nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ——, 19 55, to JUNE 16, 19 57, that I last saw the deceased alive on JUNE 15, 19 57, and that death occurred at 9:35 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George A. Grey, Jr. M.D. ADDRESS (Street, city or town, state): 104 Chevy Chase Drive, Chevy Chase 15 Maryland DATE SIGNED: 6/16/57

PHYSICIAN'S NAME (Type): George A. Grey, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/18/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 6-24-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06587

6600

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 2 yrs 11½ mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Asbury Methodist Home for the Aged

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (Rockdale 03 x 22
d. STREET ADDRESS: 8338 Liberty Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 90

3. NAME OF DECEASED (Type or print): First Annie; Middle Margaret; Last Ward

4. DATE OF DEATH: Month June; Day 28; Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: August 27, 1879

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Rockdale, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

I

13. FATHER'S NAME: Martin Luther Jean

14. MOTHER'S MAIDEN NAME: Katherine Rebecca Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Asbury Home records Address: Gaithersburg, Md.

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b) Hypertension Cardio vascular heart disease
DUE TO
(c)

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 331 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

0

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-24, 1957, to 6-28, 1957, that I last saw the deceased alive on 6-28, 1957, and that death accurred at 8:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sarah E. Glover M.D. ADDRESS (Street, city or town, state): 4308 Anthony ST Hyattsville Md. DATE SIGNED: 6-28-57

PHYSICIAN'S NAME (Type): Sarah E. Glover, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/15/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cem.

22d. LOCATION (City, town, or county) (State): Randallstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner & Sons - Baltimore Md. ADDRESS

24a. REC'D BY REGISTRAR DATE JUL 1 1957

24b. REGISTRAR'S SIGNATURE: Alverda Hodges

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06588

6601

CERTIFICATE OF DEATH

Reg. Dist. No. 214

M

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 36 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9027 GEORGIA AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 9027 GEORGIA AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First FRED Middle LEWIS Last WATERS
4. DATE OF DEATH: Month JUNE Day 25 Year 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 19, 1880
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: MENS CLOTHING
11. BIRTHPLACE (State or foreign country): EDNOR, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOS. WATERS
14. MOTHER'S MAIDEN NAME: MARTHA DAWSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ALICE HENRIETTA WATERS Address: 9027 GEORGIA AVE SILVER SPRING MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cerebro-vascular accident
931X
DUE TO (b): cerebro-arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 6 WKS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 612X Prostatic resection April 1957
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 1956 to June 25, 1957 that I last saw the deceased alive on 6-24, 1957, and that death occurred at 1:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. M. Ballinger M.D. ADDRESS (Street, city or town, state): 1801 Eye N.W. DATE SIGNED: 6-25-57

PHYSICIAN'S NAME (Type): WM. M. BALLINGER 1801 EYE ST. N.W. WASH. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: JUNE 27, 1957
22c. NAME OF CEMETERY OR CREMATORY: UNION CEMETERY
22d. LOCATION (City, town, or county) (State): BURTONSVILLE, Montgomery Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 254 CARROLL ST NW DC
24a. REC'D BY REGISTRAR DATE: JUN 28 1957
24b. REGISTRAR'S SIGNATURE: Frances Pattey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6459

CERTIFICATE OF DEATH

06589

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver spring 56
d. STREET ADDRESS: 1008 South Mansion Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Frederick Last Warfield
4. DATE OF DEATH: Month June Day 2 Year 1957
5. SEX: M
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/29/82
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): electrical contractor
10b. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: John Albert warfield
14. MOTHER'S MAIDEN NAME: Ellen Stunkle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infarcts of lungs, recent — INTERVAL BETWEEN ONSET AND DEATH: few days
DUE TO (b) Embolism of pulmonary arteries — " "
DUE TO (c)

465X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Heart disease of uncertain type (? endocardial fibroelastosis)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 10, 1957, to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas W Harnsberger M.D. ADDRESS (Street, city or town, state): 4201 NEW HAMP. AVE N.W. DATE SIGNED:
PHYSICIAN'S NAME (Type): CHAS. W. HARNSBERGER WASHINGTON D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/5/57
22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CEMETERY
22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warren E. Pumphrey, ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR: DATE: JUN 9 - 1957
24b. REGISTRAR'S SIGNATURE: J. Wilm Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6602

CERTIFICATE OF DEATH

06590

Reg. Dist. No. 216

M

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookmount
c. LENGTH OF STAY IN 1b: 1yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookmount,
d. STREET ADDRESS: 6430 Brooks Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Rose — Last: Watkins

4. DATE OF DEATH: Month: June — Day: 14 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 21-1874
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home Work
11. BIRTHPLACE (State or foreign country): Baltimore Md,
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Basil Buxton
14. MOTHER'S MAIDEN NAME: Lavenia Brandenburg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs John H. Shuemaker. Address: ~~6430 Brookslane~~ Washing 16 D C,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b): Arteriosclerosis, Hypertension — 3 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
447X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 25, 1957, to June 14, 1957, that I last saw the deceased alive on June 12, 1957, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E. Rudnai M.D. — ADDRESS (Street, city or town, state): 5120 Nebraska Ave. Washington D.C. — DATE SIGNED: 6/14/57

PHYSICIAN'S NAME (Type): ANDREW E. RUDNAI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-16-57
22c. NAME OF CEMETERY OR CREMATORY: Montgomery
22d. LOCATION (City, town, or county) (State): Damascus Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. — ADDRESS: Gaithersburg. Md.
24a. REC'D BY REGISTRAR DATE 6-18-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6603

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06591
Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): FRANKLIN & WIRE AVE. at Bus Stop

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 9113 WIRE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERBERT Middle A Last WATKINS
4. DATE OF DEATH: Month JUNE Day 13 Year 19 57
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/31/03
9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DELIVERY CLERK
10b. KIND OF BUSINESS OR INDUSTRY: Woodward & Lothrop Department Store
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: HERBERT A. WATKINS
14. MOTHER'S MAIDEN NAME: MARY ELLEN CALLAHAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-10-6152
17. INFORMANT: Miss Regina C. Watkins, 9113 Wire Ave. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: June 13, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/15/57
22c. NAME OF CEMETERY OR CREMATORY: Holy Rood Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 6/17/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

6604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06592

Reg. Dist. No.

M

I

51

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USNH, NNMC, BETHESDA, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York — ~~Virginia~~
b. COUNTY: ~~Arlington~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Aurora 69x-3
d. STREET ADDRESS: 71 Glen Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: William — Last: WERTMAN

4. DATE OF DEATH: Month: June — Day: 15 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 30 May 1936
9. AGE (In years last birthday): 21 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur WERTMAN
14. MOTHER'S MAIDEN NAME: Thelma VALLES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 4-12-56-6-15-57
16. SOCIAL SECURITY NO.: 112 30 6490
17. INFORMANT: Official Navy Records — Address: ~~Official Navy Records~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
9028.
DUE TO
(b) Fracture of C-5 with laceration of cord — 42 hours
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Dived from eight foot board into shallow water while swimming
20c. TIME OF INJURY: Hour ~~XX~~ p. m. — Month, Day, Year: 6-13 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Timberlake
20f. (City or town): Oaktone — (County) — (State): Virginia

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 16 June 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-21-57
22c. NAME OF CEMETERY OR CREMATORY: Saint Matthews Cemetery
22d. LOCATION (City, town, or county): Buffalo — (State): New York

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md
24a. REC'D BY REGISTRAR — DATE: 6-17-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6605

CERTIFICATE OF DEATH

06593 214

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RD1 Silver Spring
c. LENGTH OF STAY IN 1b: 13-6-57
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bradford Rest Home RD1, Silver Spring

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover, Md. 16x22
d. STREET ADDRESS: 1107 Ardwick Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

90

3. NAME OF DECEASED (Type or print): First Blanche Middle White Last
4. DATE OF DEATH: Month 6 Day 25 Year 1957
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: 6-2-93
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Anderson, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Hawthorne Brown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Medical Records, Mont. County H.D. Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthritis, Ankylosing of Spine, Chronic Con. fail.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): 725X
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-17, 1957, to 6-25, 1957, that I last saw the deceased alive on 6-19, 1957, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clive E. Jackson M.D. M.D. ADDRESS (Street, city or town, state): RD1 Gaithersburg, Md. DATE SIGNED:
PHYSICIAN'S NAME (Type): CLIVE E. JACKSON

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 6-25-57
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or county) (State): Suitland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Virgil Rollins ADDRESS: 4339 Hunt Rd. Mt. Rainier
24a. REC'D BY REGISTRAR DATE: 6-30-57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06594

Reg. Dist. No. 214

M

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): B & O R R tracks near N, Takoma R R Bridge

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1103 5th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sandy Middle: White Last:
4. DATE OF DEATH: Month: 6 Day: 7 Year: 19 57

5. SEX: male
6. COLOR OR RACE: col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/5/1884
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary White Address: 11-3 5th St, N. W. Wash. D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral and Thoracic Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Fracture of skull and Crushed chest (rt)
DUE TO (c):

802x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Compound Fracture of rt elbow

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Apparently struck by train while sitting along RR tracks
20c. TIME OF INJURY: Hour 7 a. m. ☒ p. m. Month, Day, Year: 6/7/57, 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): B&O RR
20f. (City or town): Silver Spring (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Brosohart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Brosohart
DATE SIGNED: 6/7/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 6/7/57
22c. NAME OF CEMETERY OR CREMATORY: Morris Carter Funeral Home,
22d. LOCATION (City, town, or county): Washington, D. C. (State):

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: JUN 13 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6607 **CERTIFICATE OF DEATH** 06595

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 405 Per shing Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 405 Pershing Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Agnes Last Foley Wilcox

4. DATE OF DEATH: Month June Day 20, Year 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/8/1900

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas F. Foley

14. MOTHER'S MAIDEN NAME: Elizabeth Connell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Francis M. Wilcox — Address: 405 Pershing Drive, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 19 40, to June 20, 19 57, that I last saw the deceased alive on June 20, 19 57, and that death occurred at 2:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. C. Kirchner M.D. — ADDRESS (Street, city or town, state): 6480 - N. W. Ave Takoma Park Md — DATE SIGNED:

PHYSICIAN'S NAME (Type): R. C. KIRCHNER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/24/1957

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co. — ADDRESS: 2901 14th St., N.W. Wash. DC

24a. REC'D BY REGISTRAR DATE: JUN 21 1957

24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6608 **CERTIFICATE OF DEATH** 07717

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedarcroft Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA ~~Virginia~~ b. COUNTY: ~~Fairfax~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WAYNE ~~432 Argyle Drive, Falls Church~~ 75 X-3
d. STREET ADDRESS: 336 CONESTOGA ROAD ~~12101 Columbia Pike~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Richard Middle: Francis Last: Wood, Jr.
4. DATE OF DEATH: Month: June Day: 20 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 1, 1885
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Broker- retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Francis Wood
14. MOTHER'S MAIDEN NAME: Mary E. Leaming ~~Surname - Leming~~
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Mexican - 1st World
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edwin Bonsack, Jr., 432 Argyle Drive, Falls Ch. - Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: a few minutes
DUE TO
(b) Coronary Sclerosis — 2
DUE TO
(c) General arterio-Sclerosis — 2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral arterio-Sclerosis & Psychosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1957, to June 20, 1957, that I last saw the deceased alive on June 19, 1957, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alvin J. Kistler M.D. ADDRESS (Street, city or town, state): Cedarcroft Sam. & Hosp. Silver Spring, Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): Alvin J. Kistler, M. D. Cedarcroft Sanitarium & Hospital, Silver Spg.

22a. BURIAL, CREMATION, REMOVAL (Specify): Trans. & Burial
22b. DATE THEREOF: 6/24/57
22c. NAME OF CEMETERY OR CREMATORY: Old Saint David's Cemetery
22d. LOCATION (City, town, or county) (State): Devon, Pennsylvania Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey, ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: July 1/57
24b. REGISTRAR'S SIGNATURE: Frances Porter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6609

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06596

Reg. Dist. No. 216

M

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6901 Cornat Dr.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6901 Cornat Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maria — Middle: Beard — Last: Worrell

4. DATE OF DEATH: Month: 6 — Day: 19 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 7-27-80

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Christian Scientist practitioner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Stephen Beard

14. MOTHER'S MAIDEN NAME: Mattie Woodward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary W. Edwards — Address: Ster 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO
(b): Chronic cardio-renal disease — 7
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-19-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6-19-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons
ADDRESS: 1756 Pennsylvania Ave. N.W.
24a. REC'D BY REGISTRAR DATE: 6-21-57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompkins

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06597

6610

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg.
c. LENGTH OF STAY IN 1b: 25yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 14 E. Diamond Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lydia — Middle: Anna — Last: Younkins

4. DATE OF DEATH: Month: June — Day: 17 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec 7-1888
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months: 6, Days: 10 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home Work
11. BIRTHPLACE (State or foreign country): Middletown. Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Martin L. Flook
14. MOTHER'S MAIDEN NAME: Sarah Jennings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: L. Reynolds Younkins. — Address: Gaithersburg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 3 HOURS
331X
DUE TO
(b) ARTERIAL HYPERTENSION — 10 YRS
DUE TO
(c) ARTERIOSCLEROSIS — 10 YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE
450.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE 1, 1957 to JUNE 17, 1957 that I last saw the deceased alive on JUNE 17, 1957, and that death occurred at 11:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon S Rosenberger M.D. — ADDRESS (Street, city or town, state): — DATE SIGNED: 17 June 1957

PHYSICIAN'S NAME (Type): Gordon S. Rosenberger — Gaithersburg. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-19-57
22c. NAME OF CEMETERY OR CREMATORY: Reformed Cemetery
22d. LOCATION (City, town, or county) (State): Middletown. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner, — ADDRESS: Gaithersburg. Md.
24a. REC'D BY REGISTRAR — DATE: June 18-57
24b. REGISTRAR'S SIGNATURE: Edwin L. Cooke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55